DOCUMENT RESUME

ED 469 036 CE 082 510

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TITLE	Alcohol and Other Drugs: Realities for You and Your Family. Health Promotion for Adult Literacy Students: An Empowering Approach.
INSTITUTION	Hudson River Center for Program Development, Glenmont, NY.
SPONS AGENCY	New York State Univ. System, Albany.; New York State Education Dept., Albany. Office of Workforce Preparation and Continuing Education.
PUB DATE	1994-00-00
NOTE	107p.; Funded under Section 326 of the Adult Education Act. Contributing authors were Colleen Bodane and Robin Granger Rischbieter.
AVAILABLE FROM	For full text: http://www.hudrivctr.org/dnload.htm#alcoh.
PUB TYPE	Guides - Classroom - Teacher (052)
EDRS PRICE	EDRS Price MF01/PC05 Plus Postage.
DESCRIPTORS	Adult Basic Education; Adult Learning; *Adult Literacy; Adult Students; Counseling Services; Definitions; Evaluation Criteria; Family Problems; Family Violence; Fused Curriculum; Glossaries; Guidelines; *Health Promotion; Helping Relationship; Instructional Materials; *Integrated Curriculum; Learning Modules; Lesson Plans; *Literacy Education; Medical Services; National Organizations; Nonprofit Organizations; Prevention; Rehabilitation Programs; Risk; Self Evaluation (Individuals); Self Help Programs; Social Support Groups; *Student Empowerment; *Substance Abuse
IDENTIFIERS	*New York; Relapse

ABSTRACT

This document is a learning module designed to provide adult literacy practitioners in New York and elsewhere with the materials needed to take an empowering approach to helping adult literacy learners deal with the realities of alcohol and other drug issues affecting them and their families. The module includes background material, information on resources, and sample lesson plans for use by instructors themselves or by guest presenters. The document begins with reading materials on the following topics: the history of substance abuse; substance use versus nonuse; elements of risk; associated risks; prevention; treatment options; self-help programs; recovery; and substance abuse in others around us. Presented next are nine sample lesson plans. Each lesson plan contains some or all of the following: a goal, outcome objective, listing of recommended instructional materials and resources; learning activities; and supplementary notes. The following materials are also included: 4 handouts; the addresses of 18 resource organizations nationwide; the addresses of 13 branches of New York's Office of Alcoholism and Substance Abuse Services; a bibliography of 39 print resources; appendixes containing information on 9 groups of drugs and criteria for diagnosing substance abuse; a glossary; an acronyms list; and a list of terms related to 12-step and recovery programs. (MN)

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An Empowering Approach

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Alcohol and Other Drugs: Realities for You and Your Family

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Acknowledgements

We would like to thank all who contributed to the production of this guide. Carol Jabonaski and Cynthia Laks encouraged us and suggested refinements. Teachers and students from adult literacy programs reviewed the draft document and provided good suggestions for improvement. Alice McDowell provided constructive feedback to us, as well as excellent insight on relapse and relapse prevention. Appreciation goes to Kim Peavey for producing excellent scripts for the audiotapes. Barbara Smith was very generous with her time and helpful with constructive comments. Kay Peavey's contributions were substantial including editing and content suggestions as well as supervision of its publication. Finally, we would like to thank Peter Cornish, Ph.D. for ensuring the timeliness of our materials.

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(Funds Provided by: The University of the State of New York, The State Education Department, Office of Workforce Preparation and Continuing Education, under Section 353 of the Adult Education Act)

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INTRODUCTION

Drug cartels, the War on Drugs, MADD, SADD, DWI: everyday a news story about alcohol or another drug grabs our attention. While international and national events may loom large, it's most often the local scene that brings us our most painful tragedies, and our greatest prospects for change.

This module provides you, the educator, with material to help you deal with the realities of alcohol and other drug issues within the adult literacy system today. It includes background material, information on resources, and sample lesson plans for use by you or guest presenters.

Please note that the subject area is vast, somewhat daunting, and continuously changing. All of us have very different expertise, interests, and needs in approaching this subject. With that in mind, a variety of topics are covered in this module. Feel free to review the table of contents, and select those sections of greatest interest to you and your students.

Some of the questions raised about alcohol and other drugs include:

-- How do we keep track of, and make sense out of, all the different types of drugs out there today?

-- What do we do if a student, or the student's family member, comes into the classroom under the influence of alcohol or other drugs?

-- How do we handle counseling needs? What can we do to support recovery? What about preventing alcohol and other drug problems in the first place?

These are just a few of the areas covered in this module. Let's begin by taking a look at how we got where we are.

HISTORY[1]

The history of alcohol and drug use is long and varied, with alcohol use before biblical times. Alcohol and other drug use was significant in this land while it was still an early British colony. Alcohol and tobacco were well in place a century before the American Revolution. The next two hundred years saw a host of new drugs - opium, cocaine, morphine, heroin, marijuana, LSD, etc. - rise and fall. Each arrived with the often naive belief that it was a new remedy for a variety of problems without the side effects of earlier substances. One example of wide availability is the presence of cocaine in the early days of Coca Cola®.

Throughout this period, there were attempts at control: through moralizing, through criminal penalties, and often through increasing controls on access to or distribution of drugs. This included an increasing separation of some drugs (notably alcohol, caffeine, and nicotine) from other "illicit" (though sometimes less harmful) drugs. Mixed messages about which drugs were relatively acceptable ("soft" drugs) and which were not acceptable ("hard" drugs) were thus reinforced. Alcohol and tobacco in particular were often treated more like foods than drugs. This is seen in their continued widespread advertising and use. Alcohol and tobacco have also been major sources of tax revenue, and issuance of these substances to soldiers reveals their acceptance by the government.

A new focus on the nature of alcohol and drug problems - trying new ways of understanding their causes - began in the 1800s. The concepts of addiction, disease, treatment, and recovery have really developed in the last 60 years, especially since the founding of the mutual self-help group Alcoholics Anonymous in 1935. Many other groups borrowed from the AA model, such as Alanon (for family members and significant others of alcoholic persons) and Narcotics Anonymous (NA). Citizen groups such as Mothers Against Drunk Driving (MADD), Students Against Drunk Driving (SADD), and Remove the Intoxicated Driver (RID) brought major public attention and pressure on policymakers to make changes in law. Organizations such as the National Council on Alcoholism led efforts in the areas of public and professional education. As advocacy and education successes grew, identification, referral, and treatment services were increasingly established around the country.

Perhaps the greatest growth has resulted from the move of alcohol and other drug problems into open public discussion. This was encouraged by the growing stream of famous persons who publicly shared their recovery stories, after the prominent lead of former First Lady Betty Ford. Only in the last 10 to 20 years has there been consistent public focus on the issue of drug (and even alcohol) problems, as well as an emphasis on the fact that recovery is indeed possible, and a focus on the collective need to work now to prevent such problems before they develop. "Drug Free School Zone" signs are common symbols of this increasing community concern.

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[1] Historical landmarks in U.S. drawn from *The Core Curriculum of Addictions Nursing*, 1990, L. Jack (ed.), National Nurse's Society on Addictions, Skokie, IL.

Alcohol continues to be the number one drug of choice, even while other drug use declines. More and more attention is paid to prevention efforts such as the DARE (Drug Awareness Resistance Education) program. Although advertising remains a concern, there are now significant other messages encouraging young people to remain drug and alcohol free. There is also more sensitivity about alcohol and drug use by adults: less tolerance for public intoxication and driving while under the influence, and a bigger push for individual action ("Friends don't let friends drive drunk," establishment of designated driver programs, etc.).

A Drug is a Drug is a Drug (Or, Is It?)

The varied history of alcohol and other drug problems has brought about a maze of organizations and institutions, resulting in complicated public policy efforts to try to solve the problem. On the federal level, for instance, a single agency does not oversee all alcohol- and drug-related problems. Instead, there is the:

-- Food and Drug Administration
-- Drug Enforcement Administration
-- Bureau of Alcohol, Tobacco and Firearms
-- National Institute on Alcoholism and Alcohol Abuse (NIAAA)
-- National Institute on Drug Abuse (NIDA)
-- Office of the Surgeon General, et.al.

Since alcohol and tobacco are legalized sources of considerable tax revenue, and have sizeable political lobbies as well, work in these areas is particularly sensitive. Actions concerning prescription drugs catch the interest of drug companies, assorted health professional groups, and other lobbying interests such as the insurance industry and senior citizen groups. Illicit drugs also involve the law enforcement and criminal justice communities, U.S. Customs, and various elements of the U.S Armed Forces. It is easy to understand the creation of the "drug czar" post as a step toward coordinating all of these efforts.

In addition to all the above influences, there are even more complexities in New York State, such as the State Liquor Authority, the local Alcohol Beverage Control Boards, and the Department of Health. The "alcohol field" of treatment services grew out of a combination of areas, including the self-help movement and the health and mental health systems. The "drug field" grew out of early efforts at narcotics and other drug control, and evolved to also include recovering addicts and various medical approaches. Two "sister agencies" in the treatment area, the New York State Division of Alcoholism and Alcohol Abuse (DAAA) and the New York State Division of Substance Abuse Services (DSAS), were recently administratively connected under the umbrella name *NYS Office of Alcoholism and Substance Abuse Services* (OASAS). Its goals are to streamline and consolidate services in order to better meet the needs of the public. This will be no small task, as it represents one of the largest such collections of services in the world. It is a beginning, however, to an integrated public approach to alcohol and other drug problems in what is still a relatively very young field.

A Word or Two about Words

At first, these different influences may seem trivial, but they have a tremendous direct influence on the kinds of funds and services available to you, and even on the language used in this module. Each system has used different terms to talk about the same issues. For example, to many people the word "drug" does not include alcohol (or nicotine, or caffeine). The term "substance abuse" may refer to chemicals other than alcohol, or to illicit drugs; to some it includes addiction and to others it does not. Likewise, the term "chemical dependency" may or may not include alcohol, or problem use that does not necessarily mean dependence. To be as clear as possible and to avoid the risk of overlooking alcohol, the authors of this document use the terms "use of alcohol and other drugs," "problems with alcohol and other drugs," and the generic terms addiction and dependence to relate to any or all discussed drugs including alcohol, unless otherwise noted.

THE FIRST CHOICE: USE VERSUS NON-USE

Communities often feel powerless and fearful because of the prevailing notion that alcohol/other drug problems are a fact of life for all: pervasive and inevitable. The actual numbers paint a far different picture. Over 30 percent of American adults, for instance, don't drink alcohol. Most Americans have never used cocaine. Some cite religious reasons, some a history of alcohol or other drug-related family problems, others the onset of recovery, and some just identify the choice as part of a healthier lifestyle.

The first choice, then, for individuals to consider for themselves and for their children is not when or how to start use, but whether or not to use at all. People who have used in the past must decide whether or not to continue using at this point in their lives. The information in this module can help educated consumers make an informed decision that is consistent with their personal values, by exploring areas such as pharmacology, and problem use versus non-problem use.

ELEMENTS OF RISK

Chemical Risk Factors

The first couple of areas of importance are the nature of the drug itself, its particular characteristics, its actions, and its effects. It's possible to get a good working understanding of the basics, as much of it can be boiled down to some easy-to-remember principles. This section will begin with an overview of these basics, and then address specific drugs in somewhat greater detail.

As used here, the term "drug" is used to refer to any chemical (other than food) which is taken into the body to produce a certain effect. The drug may be taken into the body by a variety of routes and methods:

-- by eating or drinking (ingestion)
-- by smoking
-- by inhaling through the nose
-- by injecting into the skin, muscle or a blood vessel
-- by absorption through contact with the skin or mucous membranes (as with ointments, skin patches, or suppositories).

The drug may be taken "straight" (all by itself), or mixed with liquid or food or other drugs. The possible options are limited only by creativity, and no effort will be made here to speak to all the possible cases.

While not belittling the susceptibility of people to addiction to prescription drugs, we are instead focusing on the personal use of drugs (including alcohol) *outside* prescribed treatment by a physician. This use is of public concern because it involves use of drugs in ways or amounts other than therapeutically intended, because of the negative consequences of such use, or both. So, this could include the use of alcohol and other drugs by minors, illegal drugs, and over-the-counter or prescription drugs in ways that are problematic.

Drugs work in a variety of ways, affecting one or more systems of the body. They usually are known by:

-- their main area or type of effect (e.g., "cardiac drugs" work primarily on the heart)
-- what the drug is made from (e.g., "opiates" are drugs which are made from parts of the opium poppy)
-- how they are taken (e.g., "sniffers" or "poppers").

There are many, many different drugs available, with more being developed every day. There are also different ways of naming and referring to drugs, including chemical names, trademarked names, and "street" or slang names. It is difficult to keep track of all this information even if it's your line of work, and there really is no need to try. There are numerous reference guides in which you can look up the nitty gritty details any time you

wish. We emphasize developing a basic sense of major characteristics and themes so that they are easier to remember.

Some Basic Drug Groups

Drugs of public concern are typically those that affect the central nervous system (CNS), which is the brain, spinal cord, and associated nerves. Interestingly, we are learning more and more that these drugs parallel, imitate, and interact with natural internal systems in the human brain that create mood swings and the experience of pleasure, and affect thought and behavior. Such external drugs affect mood, perception, thinking, judgment, and coordination. They can also affect the life systems under the control of the brain such as consciousness, heart rate, and breathing.

A simple framework to use for understanding the effects of different drugs is to put them into three main categories:

-- Depressants ("downers"): drugs that slow down, or depress, the CNS
-- Stimulants ("uppers"): drugs that speed up, or stimulate, the CNS
-- Others (hallucinogens, etc): drugs that primarily produce other effects including hallucinations, which are images, sensations and perceptions of things which differ greatly from physical reality.

Once you understand how a specific drug in one group works, you will have a pretty good sense about how the rest of the drugs in that group are likely to act.

Depressants (Downers)	**Stimulants** (Uppers)	**Other Kinds of Drugs**
Alcohol	Caffeine	Marijuana
Tranquilizers	Amphetamines	Hallucinogens (LSD, PCP, psilocybin)
Barbiturates	Cocaine	Inhalants
Narcotics	Nicotine	Steroids

An example of a depressant drug is ethyl or "beverage" alcohol. This is sometimes surprising to people, who may have experienced an "up" feeling after drinking alcohol. Alcohol is classified as a depressant drug because it depresses the CNS. It also loosens inhibitions. Depressing inhibitions can give the drinker an initial feeling of being stimulated or energized. The amount of depressant effect depends on a number of factors, such as whether it is in a more concentrated form, which is called a higher "proof" (for instance, a shot of whiskey) or a larger dose (a quart of beer). A number of factors about the individual drinker and the environment (both emotional and physical) in which the alcohol is consumed also influences the strength of the depressant effect. Generally, the depressant effect increases as the amount

of alcohol in the drinker increases. Effects range from a loosening of inhibitions to impaired judgement, change in mood, decrease in motor coordination, depressed heartrate, and breathing, to loss of consciousness and death in overdose. Other examples of CNS depressant drugs include:

-- tranquilizers like diazepam [Valium®]
-- narcotics like codeine and heroin
-- barbiturates like phenobarbital and secobarbital [Seconal®].

Amphetamines, which are also referred to as "speed" because the user's CNS feels speeded up or "cranked" up, is an example of a CNS stimulant drug. Such drugs:

-- increase CNS activities like breathing and heartrate.
-- give a sense of increased energy without eating. (This can lead to wide and often problematic use for weight loss.)

Other examples of CNS stimulants are: caffeine, nicotine, and cocaine. Of these three, cocaine is often seen as the most powerful and dramatic. It produces a very strong stimulant effect quickly, so that the user may feel an exaggerated sense of power and invincibility. Concentrated as crack cocaine, the effects are even faster. The resultant drive to use again is often instantly planted. The association of crack with crime and fear is strong in the public mind because of the anguish that comes with crack cocaine for its users, their families, and even passersby, and because of the devastation of many communities.

Far and away the "upper" drug with the greatest cost in life and health reported so far is nicotine. Although drastic changes in public policy around smoking and health have begun to intensify in the last several years, the Centers for Disease Control and Prevention (CDC) still reports that:

-- In the U.S. in 1990, cigarette smoking was directly responsible for 20 percent of all deaths - more than alcohol, other drugs, car crashes, and AIDS put together. (This figure doesn't include indirect effects of smoking, or the use of cigars or pipes.)
-- Smokers lose an average of seven minutes of life for each cigarette smoked.[2]

The aftereffect of each of both depressants and stimulants is generally the opposite of the group's initial effect. In other words, when the effects of depressant drugs are wearing off, an opposite stimulant effect is then experienced. For example, a drinker may go to sleep after a number of drinks and wake up feeling irritable and restless, or even wake up earlier than anticipated. Similarly, when the effects of a stimulant drug are wearing off, a depressed effect remains (e.g., someone coming off a speed run or a cocaine high typically experiences a "rebound" level of depression). The user often is not aware of the nature of this rebound effect, and may brush it off or regard it as a signal to re-drug themselves.

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[2] *NY Times*, August 27, 1993

Examples of drugs that fall into the "other" category (neither an upper nor a downer) are drugs that produce hallucinogenic effects, such as:

-- LSD. This "acid" became famous in 1960s America and produces a variety of often vivid visual hallucinations - sometimes peaceful and sometimes terrifying.
-- psilocybin or "magic mushroom."
-- PCP or "angel dust." Persons using PCP might become very paranoid and afraid or act as if the hallucinations are real. They might also become injured without realizing it, because the drug deadens their perception of pain.

Marijuana and steroids are also included in this unofficial "others" grouping, as they are neither uppers nor downers and have special effects of their own.

Besides the primary effects of these groups of drugs, there are side effects as well. Alcohol, for instance, is an irritant to a variety of organs, and can even cause:

-- high blood pressure
-- ulcers
-- infections
-- memory problems
-- sleep problems.

Snorting cocaine, or even over-the-counter (OTC) decongestant nasal sprays, can cause ulcers in the lining of the inside of the nose, and even holes through the septum or middle wall.

Drug Effects Depend on Amount and other Factors

The signs and symptoms, then, of particular drug use can arise both because of the nature and actions of that drug in one time use, and a result of repeated amounts or doses of the drug over varying amounts of time. Generally speaking, smaller and younger or elderly persons are affected more strongly by small doses of a drug. Their bodies have to do more work to get rid of the drug. It appears as though women may react to smaller doses as well, but more study that focuses on women's use and effects is needed.

Overall health, use of other drugs, and allergies or illnesses are other factors that can affect how a person responds to a given dose of a drug, and even how the same person responds to a drug at different times. The quality of the drug and whether or not it has been "cut" with other substances such as talc or cheaper drugs are important factors in determining the user's response or extent of problems. With some "street" drugs, such as heroin, many of the special physical problems are as a result of additives to the drug and problems in taking it (such as sharing "dirty needles"). Personal and family factors are, as we'll see shortly, very important as well. First, let's take a more specific look at a few drugs. It is useful to start with alcohol because its use is so widespread.

A Closer Look at Some CNS "Downers"

Alcohol

Alcohol is a drug. While a legal beverage for adults, it is a drug nonetheless. Other than perhaps caffeine, it is the drug of choice for all age groups in the U.S. for those who choose to use drugs. Ethyl alcohol, the kind we drink, is in the same general class of drugs as tranquilizers and barbiturates, and produces similar intoxication as other depressants or "downers."

Though technically considered a food, alcohol is high in calories (100 calories to one fluid ounce of 100-proof alcohol) with little, if any, nutritional value. It does not need to be digested in the same way as other "foods," and much of it is immediately absorbed into the bloodstream and carried to the brain.

The first effects of alcohol are lowered inhibition and impaired judgment. The drinker is more likely to be more outgoing or to make poor, drug-affected decisions, such as that to drink and drive. After more drinking, symptoms include:

flushing	dizziness
dulling of senses	impaired reflexes
lack of coordination	loss of memory.

Secondary effects of moderate drinking involve uncharacteristic emotional expression. The drinker may exhibit exaggerated happiness, aggressive anger, or depressive sadness, or any of a variety of emotions that may be affected by or even caused by the drug itself.

After consuming larger quantities of alcohol, symptoms may include:

staggering	dulled senses
slurred speech	sudden mood changes
double vision	unconsciousness.

Excessive drinking can put the body's involuntary functions such as breathing and heart rate to sleep, sometimes resulting in death. This is of particular concern with younger drinkers who are less experienced and also not fully developed physically. They may "pass out" from drinking and be allowed to "sleep it off," when they actually vomit and choke to death in their unsupervised sleep.

The effects of alcohol depend upon an individual's tolerance (sensitivity of the brain to alcohol), which appears to be inherently different among individuals. Tolerance can change when alcohol is consumed over time. As tolerance builds up, a person must drink larger amounts of alcohol to produce the same effects as when he/she was drinking less. Ultimately, the person may drink a much greater amount of alcohol without showing any outward signs of "drunkenness" or intoxication. This increase in tolerance often misleads the drinker into believing that they're doing just fine. Increasing tolerance (being able to "hold your booze" or "drink the others under the table") is one of the first warning signs of an alcohol problem.

(Ironically, if alcoholism should develop and progress into the late, chronic stage, tolerance *decreases* rapidly. The alcoholic person can become intoxicated on a much *smaller* amount of alcohol because of damage to the liver.) Tolerance is also a factor with other drugs, and with combining drugs, as we'll see later. As tolerance increases, the drinker may also begin to experience "blackouts," another warning sign. In "blackouts," the person drinking or under the influence appears to be fine, but has no recall of events later. The more often these blackouts occur, the greater the concern of dependence if the person continues to drink.

The effects of alcohol are very individualized, or specific for each person. How alcohol affects an individual depends on many factors:

-- *The amount of alcohol consumed.* The more a person drinks, the stronger the effect will be.

-- *How fast one drinks.* The faster one drinks, the higher the peak concentration in blood alcohol content and the stronger the effect will be.

-- *Presence of food while drinking.* Presence of food in the stomach slows down the absorption of alcohol somewhat.

-- *Weight.* The greater ratio of body muscle to body fat, the lower the concentration in blood alcohol content and the weaker the effect will be. However, even at the same body weight, women are more affected by the same amount of alcohol, because it is processed more slowly in women and circulates in the bloodstream longer. Effects of alcohol on women can also vary depending on where a woman is in her menstrual cycle.

-- *Mood.* If the drinker is depressed, alcohol may exaggerate that feeling. Similarly, if the drinker is ready to celebrate, drinking may magnify that mood, or may bring a sudden unexpected change in mood.

-- *Prior drinking experience.* Some people will have higher tolerance, or no tolerance at all, due to past drinking habits or lack thereof. The literature increasingly cites the possibilities of inborn differences in tolerance, related to family history of alcoholism.

-- *Mixing alcohol with other drugs, i.e., depressants.* This can be life-threatening, since a double dose of depressants could shut down bodily functions.

-- *Type of alcoholic beverage.* Carbonated mixers can increase alcohol absorption rate, while mixing alcohol with water may lower the absorption rate somewhat.

<u>Tranquilizers and Barbiturates</u>

Tranquilizers activate specific brain receptors to produce relaxation, calmness, and drowsiness. They may be taken in pill or liquid form, or may be injected into the bloodstream as a solution. Barbiturates depress the central nervous system, which causes peacefulness,

sleepiness, and intoxication. They are taken similarly, but may additionally be inserted as a rectal suppository. Both are legal to use only as prescribed by a health professional.

Some forms of tranquilizers (called "minor" tranquilizers, such as diazepam [Valium®]) are used by heroin addicts and alcoholics to produce mild intoxication or relieve withdrawal symptoms from other drug use. Stronger tranquilizers (called "major tranquilizers") are used in treating mental illness. Tranquilizers are the most widely-prescribed psychotherapeutic drug in the world, and are most involved in suicide attempts and accidental overdoses.[3]
Undesirable effects may consist of:

- -- fatigue
- -- depression
- -- memory loss
- -- blurred and double vision
- -- hallucinations.

More serious threats include:

- -- coma
- -- rapid heart rate
- -- drop in blood pressure
- -- possible death if combined with other depressants such as alcohol.

A particular concern with some of the drugs in this group is their "half-life," meaning the extent to which the drug and similar breakdown products remain in the body even after use is stopped. In some cases, this can last for weeks or even months, so careful supervision by a physician knowledgeable about addiction is very important.

See Appendix A for more information on tranquilizers.

Barbiturates are among the most dangerous, life-threatening drugs.[4] Using them can result in a gradual decline in blood pressure, heart rate, and breathing. Among the side effects are:

- -- nausea
- -- abdominal pain
- -- chronic fatigue
- -- depression.

Dangers include psychotic episodes, stopped breathing, and possible death if combined with other depressants such as alcohol. Examples include phenobarbital and secobarbital [Seconal®, Tuinal®].

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[3] Comprehensive Addiction Treatment Services, *Facts About Drugs: Tranquilizers*, 1989.

[4] Comprehensive Addiction Treatment Services, *Facts About Drugs: Downers/Barbiturates*, 1989.

To identify someone on barbiturates or tranquilizers, look for slurred speech, staggering gait, motor incoordination, drowsiness or sleep, and some confusion, especially in the elderly.

See Appendix B for more information on barbiturates.

Narcotics

The most commonly known narcotics include heroin, opium, codeine, methadone, and Demerol.® They come in the form of poppy juice, powder, or solution, and may be injected into the bloodstream (mainlining), muscle, or under the skin, or may be swallowed. Other examples include pill forms, such as Darvon.® Narcotics are illegal except as prescribed by licensed health care professionals.

Narcotics produce:

- -- an orgasmic rush of pleasure
- -- numbness
- -- lack of pain
- -- euphoria.

In addition, they depress all body systems including brain centers such as those which control breathing. Aftereffects include:

- -- anxiety
- -- depression
- -- nausea
- -- constipation.

Dangers include:

- -- possible HIV infection from unsanitary needle use
- -- not knowing the true content of street drugs
- -- severe withdrawal
- -- breathing and heart problems
- -- seizures.

Death may result from overdose or dangerous combinations with other drugs. It is important to differentiate between the prescribed use of medication and street use, and perhaps especially between the prescribed use of methadone and illegally obtained street methadone. Methadone is a man-made, synthetic narcotic which is used in the treatment of heroin addiction. Methadone may be prescribed to help a heroin addict by replacing the heroin and helping the person become stable without it. The dose of the methadone is adjusted so that the "rush" or high described above does *not* occur, and the person becomes able to return to work and other life activities while under the careful medical supervision of the methadone clinic. Methadone may be used in this way as a long-term or even lifelong support, or to help the heroin-addicted person transition more gradually to a drug-free life, first off heroin and eventually off methadone as well. Like any drug it has side effects and not all can take it, but it has been helpful in treatment. When methadone is used in a prescribed manner and

monitored by a physician or specialized methadone clinic, it is not associated with the crime and other problems of "street methadone" described above.

To identify someone on narcotics, look for euphoria, dizziness, mental confusion, constriction of the pupils, and feeling warm.

See Appendix C for more information on narcotics.

A Closer Look at Some CNS "Uppers"

Caffeine

Perhaps most often thought of as coffee, caffeine is actually available in a variety of other beverages (including some teas, colas, and noncola soft drinks) and in other food and pill forms. It produces CNS stimulation peaking within a half hour of use, and users report a feeling of relaxation and increased energy. With increasing amounts, caffeine can cause:

- -- restlessness
- -- increased pulse
- -- sleep disturbance
- -- strain on the heart
- -- increased risk of chest pain and heart attack.[5]

Amphetamines/Speed

Amphetamines, commonly called "speed," also have many other nicknames, such as bennies, black beauties, dexies, eye-openers, pep-pills, or uppers. They overstimulate the central nervous system, and give the user a rush of pleasure similar to orgasm or electric shock. Speed may be taken in capsules or tablets, may be injected into the bloodstream, or "snorted" up the nose. Amphetamines are illegal except for licensed treatment of medical disorders such as narcolepsy, Parkinson's disease, and epilepsy.

Speed may produce:

- -- increased alertness
- -- excitement
- -- reduced appetite
- -- feelings of creativity and power.

Undesirable effects may include:

- -- altered sex drive
- -- restlessness
- -- dizziness
- -- irritability

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[5] Jack, 1990.

-- paranoia.

More severe threats include:

-- needle-related hepatitis
-- AIDS (from sharing needles)
-- collapsed and blocked blood vessels
-- overwork of body systems.

Addiction to amphetamines may develop over time. The user may take another drug such as alcohol or tranquilizers to "come down" from the amphetamine high or to stop withdrawal effects. This can promote a never-ending cycle of using uppers and downers to try to feel stable.

To identify someone on "uppers" look for dilation of pupils, rapid speech, restlessness, complaints of a dry mouth, being more talkative, and having no interest in food.

See Appendix D for more detailed information on amphetamines.

Cocaine

Cocaine is a central nervous system stimulant which comes in many forms. It often comes as a powder to be snorted through the nose and absorbed through mucous membranes. The powder may also be directly applied to the membranes of the mouth, rectum or vagina. Another newer, popular form of cocaine is "crack," a dried chunk or shaving of cocaine combined with baking soda or ammonia in water, and smoked as a vapor.

Cocaine produces an orgasmic "rush," first slowing, then increasing heart and breathing rates and blood pressure. The user becomes energetic and alert, and experiences intense euphoria. The high may be followed by an intense low with depression, worry, and inability to concentrate. It is illegal unless used by a licensed physician as an anesthetic.

Cocaine is associated in the minds of many with the sudden cardiac arrest deaths of young star athletes. Dangers include:

-- stopped breathing
-- risk of crack overdose due to high concentration of the drug in the bloodstream
-- heart failure
-- overstimulation of brain and body systems.

In addition, there are numerous undesirable side effects including:

-- shaking
-- muscle twitches
-- vomiting
-- dramatic increase in body temperature
-- dramatic mood swings.

To identify someone on cocaine look for enhanced energy, dilated pupils, red eyes, restlessness, increased sociability, being more talkative, less eating and sleeping, increased sweating and pallor.

For more information on cocaine and crack cocaine, see Appendices E and F.

A Closer Look at Some "Other" Kinds of Drugs

Marijuana (Cannabis sativa, includes marijuana, hashish, and THC)
Marijuana is known by many other names: pot, cannabis, hash, weed, and reefer, among others. It has been classified both as its own characteristic category as well as a hallucinogen. The effects of all hallucinogens are unpredictable, but marijuana generally produces a feeling of contentment and relaxation with heightened perception of sight, hearing, taste, and smell. Pot is usually seen as a grey-green-brown leaf, dried like tobacco to be smoked in a "joint" (marijuana cigarette), pipe or bong. It may also be eaten in cooked or baked foods, hence the term "hash brownies." It is illegal, although the topic of potentially legalizing remains very controversial in some circles today.

Marijuana increases heart rate, lowers blood pressure, and limits control of movement. It can harmfully affect the heart, and may contribute to asthma, bronchitis, or other damage to the respiratory system. More seriously, it may cause:

- -- infertility
- -- delusions
- -- activation of latent schizophrenia.

To identify someone on marijuana, look for reddened eyes, drowsiness, or panic and anxiety, increased hunger, eating, bursts of silly laughter, memory loss, and symptoms similar to mild intoxication.

For more information on marijuana, see Appendix G.

PCP/Angel Dust
"Angel dust" is the street name for the drug phencyclidine (PCP), an illegal dissociative anesthetic which both depresses *and* stimulates the central nervous system. It is a white powder which may be swallowed as a liquid or pill, snorted, smoked in marijuana or cigarettes, or injected into the bloodstream.

PCP produces unpredictable effects including:

- -- detachment from the environment
- -- euphoria
- -- hallucinations
- -- distorted time, space, and body sensations.

It increases:

-- heart and breathing rates
-- blood pressure
-- urinary output.

Dangers include:

-- loss of painful sensations (so that a person may become physically hurt and not be aware of it)
-- states of panic lasting for several days
-- the possibility of bizarre, violent, and compulsive behavior.

Death may result from convulsions, brain hemorrhage, and kidney failure, among other things.

To identify someone on PCP, look for constricted pupils, drowsiness, dizziness, "zombie walk," memory loss, slurred speech, confusion, loss of ability to speak or move, anxiety, agitation, hallucination, or aggressive behavior.

See Appendix H for more information on PCP.

Inhalants

Inhalants are an increasingly popular drug among young people today because they are cheap and available, as well as often legal (legally purchasable, though not intended for such use). They come in the form of everyday solvents, aerosols, nitrites ("poppers"), nitrous oxide, and trichloromethane. Some common examples of these are:

anti-freeze
windshield washer fluid
paint or nail polish remover
rubber cement
typewriter correction fluid.
gasoline
fluid household cleaners
lighter fluid
airplane glue

They may be "sniffed" or "huffed" directly from a container, by inhaling vapors from a balloon or bag, or from a soaked material placed over the mouth. They may also be sprayed directly into the mouth, injected into the bloodstream, or mixed with alcohol and drunk. Inhalants:

-- produce a dizzying rush and intoxication similar to that of alcohol.
-- may distort the senses and perceptions, giving a feeling of weightlessness and separation from the environment.

Dangers include:

-- severe respiratory depression
-- toxic psychosis
-- paranoia
-- coma
-- seizures

-- brain damage.

In addition, inhaling combined substances may produce toxic effects. Death may result from "SSD" (Sudden Sniffing Death) cardiac arrest or related risks such as suffocation or reckless behavior.

To identify someone using inhalants, look for sneezing and coughing, drowsiness, irritated eyes, nose, and mouth, odor of solvent on breath, severe headaches, and vomiting or nausea.

For more information on inhalants, see Appendix I.

Steroids

Steroids are another example of a type or group of drugs which may be medically prescribed and supervised by a physician in treating a variety of medical conditions. However, they also have considerable illicit use, either through multiple independent prescriptions or through street sources of the drugs (stolen or manufactured). Anabolic steroids are not typically used to produce the mood changes of the other types of drugs, but to produce physical changes in muscle strength and size in an effort to increase athletic performance, whether in contact sports such as football or solo areas such as track and field or bodybuilding. There is particular concern about such drugs' possible effects, including:

-- interference with growth in children
-- additional strain on the heart and the immune system.

Possible signs of steroid use include:

-- significant increases in body bulk and muscle size and definition
-- significant acne across the back in males
-- mood changes such as increased aggressiveness.

There is some concern about the intensification of such behavior along with alcohol use. Oral drug use often progresses to injection of the drugs, and use of both more and more often. Fatality is possible. Because of the heightened concern about the extent of this problem in adolescent males, school nurse teachers are often a good resource to consult for further information.

Patterns of Individual Use

Patterns of individual use of alcohol and other drugs vary. Some people will use one particular drug, perhaps alcohol only or perhaps a tranquilizer only. Other persons will use more than one drug, either together or at different times, and have a preference for one drug or drug group (called their "drug of choice"). They may use this drug exclusively or mostly, and fill in with other drugs on occasion or because their drug of choice is unavailable. Some people will "dabble" or experiment with other drugs, but primarily use the one favorite. Other people will use a variety of drugs alone and in combination with each other. For instance, a

common combination is cocaine, for the "Up," followed by alcohol, to try to ease the way down.

It is common for drug use patterns to change as addiction progresses, because more drug is needed to get the same old effects, and because the person's addiction may have caused problems in health or in accessing the old drugs. The more drugs or types of drugs the person has developed problems with, the tougher the recovery can be. For instance, while recovery from alcohol dependence is difficult, recovery from combined alcohol and cocaine dependence is even more difficult.

Combining Alcohol and Other Drugs

Mixing alcohol with other drugs can be life-threatening. Consequences may include:

-- multiple addictions
-- multiple withdrawal
-- convulsions
-- coma
-- death.

It is vital to remember that one drink + one pill does *not* equal two drinks or two pills. Instead, the strength of them can be multiplied three, four, or more times. The results are unpredictable and potentially deadly.

Tolerance is a factor here as well. Persons who have tolerance to a particular drug, such as alcohol, can display similar tolerance to similar drugs in that group even though they have not taken those other drugs before. This is called "cross-tolerance." If the person takes the two drugs together, *or* still has one drug in their system from earlier in the day and then drinks on top of it, they may think they can tolerate larger amounts of them both. But tolerance does not extend to all the effects of the drugs or protect against overdose, and the person can wind up with an unintended lethal dose.

When combined with alcohol, large drug doses are extremely dangerous. Alcohol is processed or metabolized first by the liver, while other depressant drugs circulate and build up in the bloodstream, increasing their effect, and possibly reaching toxic levels. Consequences may include coma, convulsions, and respiratory failure.

Personal and Family Risk Factors

There are a variety of factors that affect whether or not a person gets into difficulty with alcohol or other drugs. One of the most important is age of first use, because the earlier alcohol and other drug use starts, the greater the chance for problems, now and later. Children and adolescents are less physically mature and can be highly sensitive to drug effects. Subject

to a variety of peer pressures, and not yet fully mature in dealing with feelings or making choices, they can get into serious difficulty on even a single occasion of use (such as crack cocaine or a marijuana joint at a party, before anyone expected it to be a problem). They can be without the life knowledge and skills necessary to prevent such situations and handle them when they do arise.

Psychological research shows that people who become alcoholic do not display abnormal pre-alcoholic personalities. Emotional and social problems linked with the disease are often the *result* of drinking, and not the cause of it. But stressful life events may also be associated with an increased risk for alcohol and other drug problems. Extraordinary pressures resulting from divorce, relocation, or unemployment may change an individual's physical and emotional state. A changed physical state alone may affect a person's reaction to alcohol or other drugs. Stressful life events may cause one to use them in an attempt to relieve anxiety or depression, or to try and feel just numb for awhile. Unfortunately, the rebound effect discussed earlier sets the person up unknowingly for greater anxiety and depression in the long run, along with an increased tendency to take larger or more frequent doses of the chemicals to try and achieve some sense of fleeting relief. This is more likely for persons who have not yet developed a variety of nonchemical means to reduce stress and achieve relaxation.

A very important factor studied especially in terms of problem alcohol use is genetics, the notion that a person may be predisposed to problems before they ever take even one drink. At the center of this research is the hypothesis that there is some inheritable difference or (differences) that affect:

- -- one's tolerance
- -- one's ability to process alcohol
- -- the affect that alcohol has on the brain
- -- or some combination of these or other areas.

It is clear, for instance, that alcoholism runs in families. This tendency has been found to be true even where the children were raised by nonalcoholic adoptive parents. The trend seems strongest for children of two alcoholic parents, and next strongest for sons of alcoholic fathers. It is a significant risk indicator for all children where such family history exists.

Since alcoholism will not develop in a person who does not drink, a genetic predisposition does not guarantee alcoholism will develop. Not all children who drink alcohol will necessarily become alcoholic, so other factors are important as well, such as the messages the person gets from family and friends about whether or not to use, what level of use is acceptable, and so forth. A related concern is to what extent, if any, does a predisposition carry over to, or exist independently for, other drugs. Counselors have long observed, for instance, that recovering heroin addicts often wind up developing an alcohol addiction after recovery from the heroin addiction. The question in research now is whether there may have been a predisposition to both before the first drink or drug was taken.

For now, the greatest predictor for those at risk is family history of problems and onset of use

by the next generations. One generation in a family full of alcohol problems may decide (as a result of feeling those problems firsthand) not to drink and, therefore, believes the problem has been beaten, only to find alcoholism in the next generation (the grandchildren). This is so common it has been nicknamed "skipping."

One of the most helpful aspects of the research on genetic predisposition is that it gives people permission, even counsel, to choose abstinence. It helps wipe out the notion of somehow having "screwed up" because they can't drink the way other people can.

Family Messages and Expectations

In addition to genetics, other important family factors are messages and expectations about use of alcohol and other drugs. Often the most powerful guidance is not what children hear, but what they see:

-- Are alcohol and other drugs used as rewards or as solutions to life problems?

-- Is alcohol and other drug use an important status symbol for the adults, and one to which the children aspire as the only marks of growing up (along with the car keys and sex)?

-- Is significant alcohol use and intoxication condoned? Is the family relieved because members think, "At least, there isn't a 'drug problem'."?

-- Are family members able to do things under the influence of alcohol and other drugs that would otherwise not be allowed?

-- Are alcohol and other drugs apparently necessary for family members to "communicate" with each other, or to medicate and manage feelings?

-- Are alcohol and other drugs a constant presence, part of the very fabric and identity of the family?

-- Are alcohol and other drugs absolutely prohibited and taboo even for discussion?

-- What about the larger family and community environment? What messages and expectations exist about use, non-use, and nonproblem use?

-- What supports are in place for youth and parents and families in this area?

These factors all combine to prepare, or not prepare, for the risks which can be associated with alcohol and other drug use. Some people, such as Schaef in When Society Becomes an Addict (1987), would also argue that these and other issues are deeply ingrained in this society, and further predispose Americans to the development of a variety of addictions.

Specific Populations

Alcohol and other drugs present potential risks for anyone, but several populations are at unique risk in different ways. The sections on the following pages present some interesting findings about different groups of people.

Women

Women in difficulty with alcohol and other drugs face special problems related to gender. Alcohol has a physiologically different effect on women, and treatment of addicts needs to reflect the reality that alcoholism affects men and women differently. When women go for help, they are more likely to go untreated than men, perhaps because addiction in women is less accepted than in men. Women addicts also suffer greater social stigma than men addicts and feel greater shame about drug abuse.[6] If accepted into treatment, women will often be subjected to male-oriented help, instead of being offered care that is appropriate to the specific problems of female addicts. Lesbians have six times as much chance of becoming alcoholic,[7] and suffer double stigma due to both gender and sexual orientation.

Some studies show that women are more likely than men to use alcohol and drugs to reduce stress, cope with life, and anesthetize painful, negative feelings.[8] The genetics-based research shows that risks are strongest for same-sexed offspring, so female children of alcoholic mothers are at higher risk of developing alcoholism than male children.[9] Daughters of alcoholic mothers are three times more likely than daughters of nonalcoholic mothers to develop alcoholism.[10] Women who are alcoholic are twice as likely as men who are alcoholic to have been raised by two alcoholic parents.[11]

The following list highlights some additional information about women and their use of alcohol, as well as other specific populations' use of alcohol:[12]

-- Sixty-eight percent of New York [State]'s adult women use alcohol.

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[6] Peluso, 1988, p. 185.

[7] Peluso, 1988, p. 192.

[8] Peluso, 1988, p. 184.

[9] NYS Division of Alcoholism and Alcohol Abuse, *COAs and Alcohol: Risky Business*, 1990.

[10] Bohman, 1981, p. 965.

[11] McKenna and Pickens, 1981, p. 1028.

[12] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol Facts: Women*, 1990.

-- An estimated 420,000 women in New York State are problem drinkers.

-- Women may develop severe liver disease with shorter durations of alcohol use and lower levels of consumption than men.

-- Drinking problems among women appear to be associated with role deprivation (*e.g.*, loss of role as wife, mother, or worker) rather than with role overload (*e.g.*, mother who works outside the home), though this does not necessarily mean that one causes the other.

-- Nearly three-fourths of alcoholic women suffer some type of sexual abuse compared to 40 percent of the general population.

Young People[13]

-- Close to 80 percent of high school dropouts today have drug-related problems.

-- Nearly two-thirds of all American youth use an illicit drug before they finish high school.

-- One in 20 high school seniors drinks alcohol daily.

-- Forty percent of American youth have used an illicit drug other than marijuana.

-- The average beginning age for alcohol use is 12.5.

-- The average beginning age for marijuana use is 11.8.

-- Every day, more than 5000 Americans try cocaine for the first time.

African Americans[14]

-- African American men who use alcohol are more likely than white men to use illicit drugs. African American youth who are heavy users of alcohol are more likely to experiment with illicit drugs and to develop heavy use patterns of illicit drugs. African American women in many surveys show higher rates of abstinence from alcohol than African American men or white American women.

-- The average life expectancy for African Americans is six years less than it is for whites. Illness and injuries that are alcohol-related, plus limited access to health care,

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[13] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol Facts: Young People*, 1991.

[14] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol Facts: African Americans*, 1991.

contribute to mortality rates.

-- Violent crimes in African American communities are linked more frequently to alcohol than to illicit drugs.

-- African Americans, especially males, are at high risk for acute and chronic alcohol-related illnesses. In some areas, African American have up to ten times the rates of liver cirrhosis than whites.

-- It appears that socioeconomic factors, such as education, poverty, and health care, are interrelated to alcohol problems in the African American community. The highest concentration of alcohol-related problems occurs among socioeconomically disadvantaged African American men. As income level increases, the number of African American men experiencing these kinds of problems declines.

-- African Americans are an increasingly popular target audience for the alcoholic beverage industry. A 1990 study showed that some radio stations targeted to African Americans have 350 percent more alcohol commercials than other stations. Black magazines show a range from 27-50 percent more alcoholic beverage ads [than other magazines].

-- Malt liquor, which contains up to 40 percent more alcohol than regular beer, is marketed primarily to African Americans and Latinos. African Americans consume one-third of all malt liquor.

Hispanics[15]

-- Overall, Hispanics have a permissive attitude about heavy alcohol use by men. Among Hispanics, machismo is culturally expected conduct for men, and for many this includes drinking large amounts of alcohol. However, the disease of alcoholism is seen as a weakness in a male's character among Hispanics.

-- Frequent and heavy drinking increases among Hispanic males during their 20s and 30s, but declines in their 40s. Rates of non-use increase after age 59.

-- In New York State, 23 percent of Hispanic males are heavy drinkers. This is the same rate as that of white males. However, 69 percent of New York's Hispanic males use alcohol, which is lower than the rest of the state's male population.

-- First generation Hispanic-American males and females have higher rates of drinking than foreign-born Hispanics. More than half of first generation males are frequent heavy drinkers.

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[15] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol Facts: Hispanics*, 1990.

-- Both income and education are found to affect drinking patterns in Hispanic men and women. Hispanics with higher incomes and/or higher levels of education have higher rates of heavy drinking and lower rates of nonuse.

-- Hispanics may not seek help for their alcohol problems, particularly outside the family unit. Cultural norms support privacy, especially for Hispanic females who may be reluctant to seek treatment because of the shame they feel about their drinking. Other barriers to treatment can be language, machismo, and lack of financial resources or insurance to pay for treatment.

Native Americans

-- Drinking behavior is highly variable from one tribe to the next.

-- Under prohibition laws on rural reservations, drinking styles are characterized by rapid consumption of beer or "bottom of the line" wines, after which there may be a long trip home, and consequently, significant single and multiple vehicle alcohol-related crashes.

-- Nationally, from 1978 to 1980, alcoholic cirrhosis caused the death of one in four Indian women, a rate 37 times that of their white counterparts. In addition, 25 percent of all Indian mothers who bear a child with fetal alcohol syndrome (FAS) give birth to another one similarly affected.[16]

-- Though research on alcohol-related problems among Native Americans is neither extensive nor conclusive, possible contributing factors include socioeconomic conditions, biological factors (possible genetic link), and social influences (intense pressure to drink).[17]

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[16] "Research Report: Alcohol and Ethnic Minorities," p. 5.

[17] "Research Report: Alcohol and Ethnic Minorities," p. 5-6.

ASSOCIATED RISKS

Fetal Alcohol Syndrome

In 1973, Jones and Smith coined the term "Fetal Alcohol Syndrome" (FAS) for a pattern of mental and physical defects originally blamed on malnutrition in the expectant mother. Today, FAS is recognized as a leading known cause of mental retardation that develops in infants born to some women who drink alcohol heavily during pregnancy. Approximately 1.9 in every 1000 children born in the world have FAS, and the disorder adds nearly $100 to the cost of *every* child born in the United States. Increase in costs is due in part to the necessary monitoring of an FAS child's health and development, the need for support groups, assistance with child care, and respite care for primary caregivers. Unlike Downs' Syndrome or other genetic birth defects, a mother can completely prevent FAS by abstaining from alcohol during pregnancy. Regardless of *when* a woman stops or reduces alcohol intake during pregnancy, the risks of alcohol exposure decrease immediately.

FAS is distinguished by a group of inborn birth defects including prenatal and postnatal growth deficiency below the 10th percentile, and facial abnormalities including:

- -- small head circumference
- -- short eye openings
- -- flattened midface
- -- sunken nasal bridge
- -- thin upper lip
- -- flattened and elongated groove in the middle upper lip.

Internally, there may be varying degrees of major organ or system malformation, and the skull or brain may be damaged. There may also be central nervous system dysfunction such as:

- -- neurological abnormalities
- -- developmental disabilities
- -- behavioral dysfunction
- -- intellectual impairment.

Less severe birth defects linked to alcohol use during pregnancy may be referred to as Fetal Alcohol Effects (FAE). Characteristics of FAE include:

- -- low birth weight
- -- irritability and hyperactivity in the newborn
- -- short attention span
- -- learning disabilities affecting memory, problem solving, coordination, impulsiveness, speech, and hearing.

FAS is not just a childhood disorder. It follows a predictable long-term progression into adulthood, becoming a lifelong problem. The effects of prenatal alcohol exposure exist on a sliding scale: FAS is at the most serious end, with more subtle symptoms at the other end.

Babies with less-than-ideal neurological responses may show small deficiencies later in daily life such as poor judgment, inadequate problem solving, or faulty memory.

It is hard to accurately measure the effects of alcohol intake during pregnancy, because we can't very well conduct controlled experiments (thereby risking the lives of unborn babies). The information we collect relies on children diagnosed with FAS at birth or later in life, then possibly followed over time. We must also rely on reports of mothers who drank during pregnancy, and they aren't necessarily accurate in estimating how much and how often. Studies reflect that women with more serious alcohol-related problems are those more likely to *under*report consumption.

The key questions remaining in FAS research are: How much alcohol during pregnancy is *too* much? *When* is the fetus at greatest risk to damage by alcohol? For now, the answers to these questions must be: *any* alcohol may be too much, and *anytime* may be the most dangerous time.

An added challenge in prevention of alcohol and other drug-related problems is the reality that a woman typically is pregnant for some time before she is aware of it. This means that important early fetal development may be affected by alcohol or other drugs before the woman even knows she is pregnant. It is therefore wise that women (and, arguably, men) who are planning conception but not yet pregnant simultaneously refrain from use that may affect conception or early fetal development.

A tremendous concern today is the toll that maternal cocaine use also has on the developing fetus, as well as identifying more effective ways to prevent these fetal effects. In addition to the physical problems of "crack babies," many of those who survive wind up in institutional care because the parents are unable to care for them, or unavailable, due to continuing addiction. Programs such as Hale House in New York City strive to provide home-like care and love to such infants and children, in the hopes of future placements with loving families who are able to provide the extra care and understanding needed. This area was identified much more recently than FAS, and is a focus of much current investigation.

HIV and Sexually Transmitted Diseases

We most often think of intravenous (IV) drugs as the only link between substance abuse and AIDS. As of February 1993 in New York State, there were 20,759 reported cases of AIDS related to IV drugs, which is 42.7 percent of the 48,580 total number of cases in the state. In all the United States, 30 percent of AIDS cases are associated with IV drug use. Therefore, it is a correct assumption that IV drug use can lead to HIV infection. However, use of alcohol or other substances may also put users at risk for HIV or other sexually transmitted diseases (STDs).

Alcohol may induce risky behaviors due to impaired judgment or loosened inhibitions. It may

also provide a rationale or excuse for behaving in a way one might not normally act. Studies show that especially among teens, sex can be unplanned and may occur more often after drinking or drug use. In a sample of 14 to 19-year-old females, 71 percent reported that it was easier to have sex if they had been drinking, and 43 percent said they worried less about birth control when drinking. Similar effects were reported from other drugs. In San Francisco, a survey showed that gay men are more likely to have intercourse after alcohol or drug use.

The effects of alcohol or drugs may prevent us from considering the risks of HIV infection before having sex. In August 1988, a study of 1,773 Massachusetts teens revealed that:

-- Those who averaged five or more drinks per day were 2.8 times less likely to use condoms than those who did not drink.

-- Those who smoked marijuana weekly were 1.9 times less likely to practice safe sex.

-- Sixteen percent of the youth who said they had sex after drinking reportedly used condoms less often.

-- Twenty-five percent who had sex after drug use said they were less likely to use condoms.

Crack cocaine has also been associated with risky sexual behaviors leading to HIV infection among adolescents and adults. Similar to alcohol, crack may increase arousal and impair judgment, leading to unplanned and unprotected sexual encounters. In addition, some male and female addicts may exchange sex for crack or for the money to buy it. The CDC has noted that cities reporting high levels of crack use also report an increase in STDs including syphilis and gonorrhea.

Drunk Driving

Though health problems such as liver disease and alcoholism develop from drinking a significant amount of alcohol over time, impairment problems can develop in one night if a person drinks enough to impair physical, mental, or emotional functioning. Impairment problems may include legal issues, job performance, fights, and more critically, drunk driving accidents.

Drinking and driving continues to be a serious social and public health problem. A 1990 National Center for Statistics and Analysis estimation shows that:

-- In 1989 alone, 45,555 people were killed in traffic accidents.

-- Some 49 percent of these deaths resulted from alcohol-related crashes.

-- Consequently, every 23 minutes in the United States a life is lost because of drunk driving.[18]

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[18] Yu, J., et al, 1991.

-- Additionally, in 1984 the National Highway Traffic Safety Administration estimated that over half of all DWI offenders were alcoholic.[19]

Research shows a clear, direct relationship between blood alcohol concentration (the percentage of blood actually made up of alcohol) and increased risks for car crashes, serious injuries, and death. A BAC reading of .02 percent means that two one-hundredths of one percent of blood is alcohol. In other words, two drops out of every 10,000 are alcohol, and the rest are blood. A reading of .08 percent equals eight one-hundredths of one percent or eight drops of every 10,000; and so forth. A person's BAC goes up according to the quantity and rate at which he/she drinks.

Since there is *always* a risk of a crash, even when one isn't drinking, the risk for accidents increases as BAC increases. The probability of a crash begins to increase significantly at .05 percent BAC, especially for adolescents and women, and risk increases dramatically after about .08 percent. The typical persons convicted of Driving While Intoxicated (DWI) have consumed the equivalent of twelve beers during a four-hour period[20], suggesting a BAC near .15 percent. For drivers with BACs above .15 percent on weekend nights, the likelihood of being killed in a single-vehicle crash is more than 380 times higher than it is for nondrinking drivers.[21] In addition, this level is so high that someone with no tolerance would have difficulty reaching it and still remain conscious.

In New York State, a person may be convicted of Driving While Ability Impaired (DWAI) with a BAC between .06 percent and .09 percent. He/she may be convicted of DWI with a BAC of .10 percent and over. To understand the relationship between BAC and drinks consumed, see the following chart.[22]

Some people believe they can "handle" drinking and driving. They don't think they've had too much to drink until they get sick, can't walk, or get arrested. They may also think that if they are really *careful* they'll be fine, or even that they drive better when drunk. The truth is that extra effort or care can't overcome the effects of impairment. We must remember that we are probably too impaired to notice poor functioning. Alcohol not only hinders motor control, but perception as well. That's why the saying is *not* "don't drink too much and drive" or "only drink a little and drive," but *is* "Don't Drink and Drive," period. Once the first drink is taken, the person's judgement about whether to have another drink, or whether he or she is safe to drive, is already impaired.

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[19] Wieczorek, W. F., et al, 1990.

[20] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol Facts: Adults*, 1990.

[21] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol Facts: Adults*, 1990.

[22] NYS Department of Motor Vehicles, *You and the Drinking Driving Laws*, 1993.

DRINKING DURING A TWO-HOUR PERIOD

Weight	No. of Drinks Consumed	Estimated BAC	Offenses
100	4	.10	DWI
140	5	.10	DWI
180	6	.10	DWI

A 12-ounce can of beer, a 5-ounce glass of wine, or a shot of 86-proof liquor all contain about the same amount of alcohol.
(Note: This gives only a basic, average view. BAC's for women may be significantly higher, at the same body weight).

Another misconception is that tolerance allows us to drink more without appearing to be impaired. A high tolerance, however, does not delay observable impairment, even though the drinker thinks he/she can drink as desired without effect. Typically, it takes about 30 minutes for the full effects of alcohol to "hit" a person, depending on that individual's tolerance, weight, what food was eaten, and so forth. Though increased tolerance lengthens this process, it only puts off the inevitable. To become impaired, one needs only to drink a quantity of alcohol that matches or exceeds his/her tolerance level. It's important to note that even those drinkers with relatively "high tolerance" are not tolerant to all the effects, and may have delayed reaction times comparable to drinkers with much lower tolerances.

As you can see, no one is invulnerable to the effects of alcohol impairment. Often the drinking and driving developed over a significant period of time, in which the driver first drank a little and drove "OK," and then drank more and more and continued to drive, without being stopped. Most drivers convicted of DWI don't even know why they have been stopped, which proves how poor perception can be when drunk. Before *anyone* drinks and drives, it's worth taking some time to think about the thousands of lives lost in alcohol-related crashes, and to review the legal penalties on Handout B[3].

Domestic Violence

Though research indicates that there is a significant connection between alcohol abuse and domestic violence and sexual abuse, it does *not* show that one causes the other.[23] Men who drink heavily do have a higher rate of domestic and severe violence than those who do not, but the majority of men classified as heavy drinkers are not batterers. In addition, the majority

[23] NYS Office for the Prevention of Domestic Violence, p. 2.

of batterers are not heavy drinkers. One study showed that nearly three-fourths of *women* in violent domestic situations are heavy drinkers.[24]

Though domestic violence and alcohol and other drug dependence are two distinct issues with different treatments, they are also inter-related in complex ways. While it may seem that violence occurs because of alcohol or other drug use or intoxication, it may actually be more likely to occur for some people *between* periods of use. Special consideration must therefore be given to the safety of family members when abstinence begins from alcohol or other drugs by the person who had been violent. Cooperation between the professionals in each treatment system is especially important here.

Addiction

As we have seen, there are a variety of types of problems one can encounter with alcohol and other drugs, whether on one occasion or over time, without being "addicted." They are problems that typically relate to the nature of the drug(s) taken and the dose, the environment in which they are consumed/experienced, and the condition of the user. There are additional problems that may be encountered as the relationship between the user and the drug intensifies. These problems fall under the umbrella of "addiction" or "dependence."

There are a number of ways ~~to~~ define addiction to or dependence on a drug. Perhaps the simplest is that persons taking a drug over time encounter problems or harmful consequences of that drug use, and continue taking the drug despite these harmful consequences. Persons may have been taking the drug for a very long time, or for a relatively short time. They may have had problems related to their use from the very beginning, or may have had a lengthy period of time where they were free of such problems. They may have begun use relative to a medical problem, or in an entirely "social" context. They may be in a highly successful career or unemployed, male or female, young, old, or in between. They may show physical signs of withdrawal when they stop use for a period of time, or they may only show signs of psychological dependence on the drug and its effects. Over time, the user becomes more and more identified with chemicals in the minds of others, and to themselves. It becomes harder and harder, the further the addiction progresses, for both the user and others to separate in their minds the person from the drug, and harder and harder to "find" the person they once knew.

One common scenario of progression into addiction/dependence is found with most cigarette smokers over time. First, the person experiments with use, and may feel different (often nauseous, but "cool"). With continued smoking and taking in of the nicotine and other chemicals, the person begins to report a sense of relaxation associated with the smoking. Gradually, the person comes to feel that he/she can no longer relax without smoking. And

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[24] Peluso, p. 188.

finally, the smoking only "takes the edge off," and feeling good isn't even part of it anymore. This pattern, based on work by Vernon Johnson, is common with many types of drug dependence, and describes well how the person's relationship with a drug begins and changes over time (1980).

Another author, Terence Gorski, describes a "Trial and Error Road to Recovery," in which a person's troubled use of alcohol and other drugs would inevitably teach the person of the need to quit, *if* the person survived long enough and *if* he/she was still physically and mentally able to recover (1982). There are easier ways to learn, indeed, but information is not enough in the face of addiction. Slogans such as "Just Say NO" to alcohol or other drugs can have some effectiveness in preventing or delaying first use, but are hopelessly outgunned once the progression has developed. The help of others is typically required.

While there are some different patterns among ethnic and racial groups and between genders, alcoholism and other drug addiction has often been called the equal opportunity disease, or "the great leveler" because it touches all groups.

There are many different signs and symptoms one may see in addiction, depending on the drug(s), the person, and other factors, but there are some strong shared themes across many situations. A commonly used professional reference in the diagnosis of alcohol and other drug problems groups the patterns under "substance dependence" or "substance abuse," and lists criteria for each that are commonly found across users (DSM-IV, 1994). Actual diagnosis is very involved and requires professional training; however, the signs of dependence on a drug may, in simplified form, include things like the following:

- -- taking the drug more or more often than the person intended
- -- a persistent wish or unsuccessful efforts to cut down or control use
- -- large amounts of time spent getting the drug, using the drug, and getting over the drug
- -- interference with fulfillment of major obligations or other important activities
- -- marked tolerance
- -- possible signs of withdrawal, and/or may use again to prevent or end withdrawal.

Substance abuse would reflect a lesser level of problematic use. See Appendix J for more information on the DSM-IV criteria.

No one sets out to become an addict. People use alcohol and other drugs for a lot of reasons, but seeking addiction is not one of them. Sometimes the addiction/dependence comes on very quickly, such as it often does with crack cocaine with its rapid rush, rapid comedown, and craving for more drug. Sometimes it develops more slowly, as it often does with alcohol, with the slower changes in use and tolerance coupled with wide availability and social acceptance. Outward appearances and real details vary, but the underlying process of addiction is a powerful hold that seems to take on a life of its own. The user and the user's family don't quite know what hit them or where or when things went so wrong.

It's easy to focus on all the risks and real problems associated with using alcohol and other drugs, but the fact of the matter is that people are drawn to them because, at least initially and in the short term, they deliver. Whether people want to feel good or just feel different, they bring about a fairly immediate (if not always predictable) result at the drop of a pill (or a snort or a drink or a shot or . . .). In the middle of using or right before using, the focus is on the here and now, not on the big picture or the future. It's common that people begin with a personal sense of invincibility (which some would call denial), never anticipating that the other guy's problem may become theirs too. An early popular book for children of alcoholic parents, by Claudia Black, is aptly titled "It Will Never Happen to Me," recognizing the common wishful promise to self, and the underlying thought that if you just do it "right" (drinking) you won't become alcoholic (or addicted) like "them."

As persons gets more and more deeply involved with the drug, the rest of the world fades increasingly to a (often irritating and nagging) backdrop. Drugs occupy more and more of the user's life and energies. The effects of the drug use help to keep the user out of full awareness of what is happening around them, because the focus is on getting that drug, now. The user's family can't understand why the user can't see what's happening. Being high helps to tune out the rest of the world, and the user does not see what the rest of their (non-drugged) world sees so plainly. As the addiction progresses, even the addicted person comes to see and feel the problems deeply, but is increasingly unable to pull free without help.

Effects of Alcohol and Drug Addiction on Family and Friends

The entire family suffers in an environment with an active alcoholic or other drug-addicted person. Alcohol or other drug use can impair the physical, emotional, and psychological health of both the user and his/her family. Its impact may manifest itself in many ways:

- -- feelings of fear, guilt, confusion, shame, or anxiety
- -- increasing anger toward the alcoholic/addicted person (or often toward the non-addicted spouse)
- -- loss of financial security
- -- feelings of conflict, insecurity, or emotional distress
- -- breakdowns in communication or role changes.

Family members are *not* responsible for the person's addiction or the resulting behavior, although that feeling may persist. Often such families have an unspoken system of "covering up" and not discussing the addiction either in the home or with outsiders. This leads to isolation as the disease progresses. The abuser withdraws from nondrinking/nonusing activities, and the family becomes reluctant to bring people home. Friends and neighbors withdraw when the addicted person's behavior becomes embarrassing or socially unacceptable.

Family and friends often adapt their behavior to adjust to abnormal conditions brought on by addiction. Every family member denies the addict's problems, and some even join in the use as a way to stay connected to the addicted person. In most cases, the isolation of addiction

causes family and friends to make excuses for the addict. Family members take on various coping roles to accommodate the now impaired addicted person and to keep the family going, but actually this often winds up enabling him/her to keep using more easily.

There are many models of the kinds of roles that are adopted in families with alcoholism or other addiction because of the unpredictable and chaotic events and communications. Claudia Black sums up the lessons the children learn as "don't talk, don't trust, don't feel" (Black, 1982). A model by Sharon Wegscheider (1985) describes how some children attempt to cope and help the family by:

- -- becoming caretakers and super achievers ("heroes" who look great but don't feel it)
- -- attempting to distract from the addiction and absorb family blame ("scapegoats")
- -- trying to help by providing humor (family "Mascot")
- -- hiding so well they become almost invisible (the "lost child").

While these roles are not carved in stone, they ring a familiar note with many children. Those now grown to adulthood may find that they continue to act out many of the aspects of their childhood roles, with a growing sense of emptiness and things being "not right," even when the addicted person is long gone. From early writings on alcoholic families (Sharon Wegscheider) to writings about adult children of alcoholics (Janet Woititz and Claudia Black), there has been an evolution around the issues of alcoholic- and other drug-addicted families. More emphasis is placed on the dysfunctional rules and roles in the family itself (which contribute to the increasing levels of addiction in subsequent generations), and less as resulting from the current addiction.

Authors such as Beattie, Schaef, and Cermak cite unhealthy characteristics of over-emphasizing the wishes and needs of others to the extent that one becomes alienated from one's true self. This is commonly referred to as codependence. The codependent is at greater risk for resorting to addictive behaviors and relationships with actively addicted people. While there is considerable debate over the science and semantics of the subject, huge numbers of people have identified with the issues. They voluntarily identify themselves as codependent persons in the process of recovery from a disease process seen as damaging as addiction to chemicals, and even more central to health and well-being. Perhaps the most widely known popular work in this area of individual and family health is the public television John Bradshaw series "On the Family."

Deciding whether or not to get treatment for the disease is the user's choice. However, family members may still seek out help for themselves to understand the disease, its effect on family life, and its impact on them as individuals. Without understanding and support, living with addiction can profoundly affect the quality of one's personal and professional life, levels of intimacy, and sense of worth throughout adulthood. There has been a great increase in awareness of such influences on the lives of many Americans, whether or not they too become dependent on alcohol and other drugs. This has encouraged many to seek the support of self-help groups, professional counseling, or both.

Although addiction is the subject of countless books, plays, and films, it continues to involve a great sense of isolation, physical illnesses, disordered thought and feelings, and growing feelings of fear and shame. Stories of successful recovery from addiction are more and more prevalent, but there are still too many who don't make it back. We'll look at treatment options, but first let's look at some ways to prevent such suffering in the first place.

PREVENTION

Any efforts at prevention need to be based on an understanding of why different people may use alcohol or other drugs, the kinds of problems likely to be encountered by those different groups, and an appreciation for the particular needs of each specific group. Some of the general reasons that people commonly give for beginning use include:

-- because it's cool, the thing to do
-- because it's handy
-- to be seen as more grown up
-- to feel better, or to feel different, to get rid of pain or to feel numb
-- curiosity
-- to relax and be able to do "x" (ask somebody out, have sex, whatever)
-- everybody's doing it
-- there's nothing else to do
-- it never occurred to me not to.

Many prevention efforts are geared toward addressing this climate and seek, through public policy and a variety of other routes, to:

-- communicate that alcohol and drug use is one of a variety of choices.
-- transmit that alcohol and drugs are less cool.
-- make alcohol and drugs less handy.
-- convey that alcohol and drugs are not effective as a long-term solution.
-- help delay the onset of initial use.
-- support abstinence as an always acceptable choice.
-- promote development of nonchemical means for achieving relaxation and reducing stress.
-- develop confidence, communication, and other life skills as preventatives against the need for alcohol and other drugs.

A parent may also help prevent drug use in his or her children by creating an atmosphere of open communication. Prevention can be effective both with the general population and with specific at-risk populations, such as young people. Who, after all, really believed even 10 years ago that there would have been such changes in smoking behavior as we have seen?

The process of addiction begins for different people at different patterns of use. Intervening before the addictive process has started and the powerful biochemical phenomena have come into action is one goal of prevention. Targeted groups for "primary prevention" include children and teens. Important "secondary prevention" efforts are targeted at groups identified at a high risk for addiction or other health problems, such as pregnant women and persons from families with a history of addiction. Another important prevention goal is the reduction of driving while "under the influence" and the numerous accidental deaths and injuries which occur as a result. *Tertiary prevention* is aimed at identifying persons with developing alcohol dependence or substance abuse. Intervening at an early stage can prevent the progression to full blown addiction with all of its accompanying health and economic costs.

Public Education

The first step in prevention is getting the facts about alcohol and other drug abuse. Myths about their use can contribute to young people getting into trouble with these substances. While use of illegal drugs is usually recognized as a dangerous activity, alcohol is often seen as "safe" because of its availability and its widespread use. Young people need to hear that alcohol is a mind altering drug. This fact needs to be clear before one makes the choice to use or not. "Choosing not to use" reflects an active process that lets people know they have a choice.

The most important messages about alcohol which OASAS has identified in prevention programs are:

-- Alcohol, in any form, is an addictive drug.
-- Alcoholism is a preventable and treatable disease.
-- Alcohol is the drug most widely used by young people.
-- Alcohol use by underage youth is unacceptable.
-- Any use of alcohol, even though not illegal, is not recommended for specific high-risk groups, e.g., children of alcoholics, pregnant women, recovering alcoholics, and addicts.
-- Any use of alcohol in high-risk situations is unsafe, e.g., driving, boating, at work, etc.
-- Intoxication under any circumstances is dangerous. ("Getting drunk is never safe.")
-- The combined use of alcohol with any other drug is dangerous.
-- Alcohol is the maintenance drug for illicit drug users, e.g., marijuana, cocaine, crack, etc.
-- Nonuse of alcohol is always an acceptable choice.
-- A drink is a drink, whether it's beer, wine, wine coolers, or distilled spirits. 12 ounces of beer, 5 ounces of wine, a 9-ounce wine cooler, and 1½ ounces of liquor all contain approximately the same amount of alcohol (0.6 ounces).
-- Fetal Alcohol Syndrome (FAS) is now recognized as the third known leading cause of birth defects with associated mental retardation in the Western World. It is the only one that is totally preventable.

Knowing the facts is a good place to start, but for prevention to be effective, it takes a little more. Young people and others at high risk need to know how to make decisions that will protect them and their health. A variety of studies have showed some promising results that young people are making those decisions. Among many of the 7-12th grade students in New York, use of most drugs has continued to decrease. That trend appears to be reflected in a survey of fifth and sixth grades recently reported by OASAS. It cites the results as "evidence that prevention works" because of the decline in use and because most students in these

groups do not use. [25]

Who Is at High Risk for Alcoholism or Health Problems?

As we've seen earlier, individual reactions to alcohol can be very different. Factors which can influence your reaction to alcohol include your weight, eating habits, sex, age, health, family background, and the amount you drink. What could be safe drinking for one person could be very dangerous for another person. If you are in one of the following groups, you need to be even more careful about alcohol consumption.

-- People with a family history of alcoholism are four times more likely to become alcoholic themselves.

-- People with diabetes, heart disease, or diseases of the digestive and nervous systems can be endangering their bodies, and should consult their doctor about drinking.

-- Older people may be more affected by the same amount of alcohol they consumed in earlier years. They may also experience complications when alcohol is mixed with other medications, and should consult their doctor.

-- Children and adolescents have a lower tolerance for alcohol and can become easily intoxicated. This group is restricted by law from alcohol consumption because of their high risk. (This risk is compounded if they drink and drive. It becomes a "triple threat" because of their sense of invincibility, immaturity, less mature development in motor skills and judgement, and newness as drivers).

-- Pregnant women who use alcohol are creating serious risks to the developing fetus. Mental retardation, spontaneous abortion, and low birth weight are some of the effects of alcohol consumption during pregnancy. There is no "safe" amount of alcohol for this group.[26]

Of course, the safest approach for all persons in these groups is to avoid using alcohol. Alcoholism, medical complications, accidental death or injuries while intoxicated, and the dangers to the developing fetus can all be eliminated by choosing not to drink.

If Not in a High-Risk Group, Is It Safe to Drink?

While it is simpler to say that using any illegal drug is not acceptable and involves risk, alcohol use is so widespread in our society that how much is too much can be confusing. Again, individual differences always play a role in how much alcohol your body can tolerate

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[25] *OASAS Today*, July-August 1993, p. 6.

[26] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol: How Much Is Too Much?*, 1991.

without becoming drunk. Intoxication is caused by the amount of alcohol in your bloodstream -- your blood alcohol concentration. When you drink alcohol at a rate that your body cannot eliminate through the liver, lungs and kidneys, your BAC increases.

Recent studies seem to indicate that up to two drinks a day (two beers, two glasses of wine, or two mixed drinks) is a "safe" level of consumption for most healthy people who are not in any of the high risk groups. Getting drunk is never safe for anyone. Although anyone can get drunk, most people don't -- most of the time.

-- Some 34 percent of American adults don't drink at all.

-- While 56 percent of American adults drink less than two drinks a day, just 10 percent of Americans drink 50 percent of all the alcohol sold.[27]

It's important to know that using alcohol involves a choice. No use or moderate use clearly puts you in the majority of adults in this country. People who are using alcohol at higher levels are putting themselves at greater risk for developing the disease of alcoholism and related health problems. Once alcoholic drinking sets in, the choice not to pick up a drink results in symptoms of withdrawal. The body's craving for alcohol for relief of these uncomfortable symptoms will usually win out over the person's choice not to drink. Without treatment or intervention of some kind, whether it be community, workplace, or school based, the disease of alcoholism will likely progress.

Community Intervention

Intervention services of some nature can be found in most communities. Local Councils on Alcoholism and Drug Abuse, for example, are broadly representative of the community and are composed of citizens who volunteer their time to:

1) provide education, advocacy, information, and referral.

2) assist in the development of community resources and services aimed at the prevention and reduction of alcohol problems.

Some of the programs which may be sponsored by local councils aimed at early intervention include Drinking Driver Programs, Family Intervention, and Treatment and Rehabilitation Services. Councils provide leadership and support for community efforts to promote alcohol awareness through a variety of local programs, including the use of local media.

Communities need to know that high-risk environments, involving inadequate compliance with laws regulating alcohol sales and distribution, can be targeted for community influence and oversight. Local councils may become involved in community prevention efforts by advocating for controls on alcohol availability and restrictions on hours of sale, and illegal sales of alcohol to minors. (For example, a New York State law, Chapter 670 of 1993,

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[27] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol: How Much Is Too Much?*, 1991.

requires community impact to be considered before granting a licenses to a facility with on-premises liquor consumption.)

Workplace Intervention

The Employee Assistance Program (EAP) is an early intervention strategy for employed persons and their families who have alcohol problems and other serious problems which interfere with their job performance. Early intervention and treatment opportunity for individuals through their workplace can be highly effective in reducing the incidence of alcoholism and other addictions.

Intervention by Schools, Students, and Parents

Opportunities for reaching adolescents about the consequences of risky behavior around drugs and alcohol are greatest in the schools and at home. Parents can become educated about the dangers around using illegal substances their children face. Programs providing support for parents on talking to their children about alcohol and drugs are available through many schools or community organizations. Parents need to be particularly aware that:

-- It is illegal to serve alcoholic beverages in the home to minors other than their own children.

-- Adults are as responsible for the serving of alcohol to people under the legal age of purchase as the person who sells alcohol under license.

-- Adults are also legally liable if a youngster has consumed alcohol in their home and becomes injured in an accident or injures someone else after leaving.[28]

The NYS health curriculum for students in grades Kindergarten through Grade 12 provides substantial information to students about the health risks associated with drug and alcohol use. Intervention in the schools is also occurring through Student Assistance Programs which link students experiencing alcohol or drug problems with effective treatment. Particular emphasis is given to children from alcoholic families. They are offered information on how to avoid alcohol problems of their own and where to get help.

Students have become involved through organizations such as SADD (Students Against Drunk Driving) to use peer education to prevent alcohol and drug abuse. Often these programs involve parents in providing young people with an alternative to riding with an intoxicated driver, or alternatives to driving for young people who are intoxicated. Promoting alcohol-free proms and other social events both in high schools and colleges is another prevention strategy which involves students, parents, and school personnel.

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[28] NYS Division of Alcoholism and Alcohol Abuse, *Alcohol, Some Thoughts for Parents*, 1992.

WHAT IS TREATMENT?

One definition of treatment is: *all* interventions intended to short-circuit alcoholism or drug addiction and to introduce the alcohol or drug addicted person to sobriety or living without the use of drugs.[29] It can include any of the following:

- Individual counseling
- Detoxification
- Family counseling
- Education
- Group therapy
- Vocational counseling
- Spiritual counseling
- AA (Alcoholics Anonymous)
- NA (Narcotics Anonymous)
- Al-Anon
- Other self-help groups

With the exception of detoxification (which usually occurs in a hospital setting), the above types of treatment can be received in either an in-patient or out-patient setting.

The many types of treatment can be confusing and very often a person will go through several of them in the course of his/her recovery from alcoholism or addiction. Abstinence from mind-altering substances is the beginning of recovery and some treatments will focus on helping the person to stop using (non-needed, nonprescribed) drugs or drinking. Other types of treatment will assist the person to build a new life without alcohol and other drugs. Let's take a brief look at what happens in some of the most widely used types of treatment, which we divided into two categories:

Professional Treatment Services
- Individual Counseling
- Education
- Group Therapy
- Children and Family Treatment

Treatment Facilities
- Alcohol Crisis Centers
- Hospital Detoxification
- Inpatient Rehabilitation Programs
- Outpatient Clinics
- Halfway Houses
- Therapeutic Communities
- Residential Chemical Dependency for Youth

Professional Treatment Services

People seeking help with problems of addiction to drugs and alcohol have a wide range of professional treatments available. Professional treatment is offered by many different professionals such as physicians, clinical psychologists, credentialed alcoholism counselors (CACs), and social workers. Most professional treatment programs also include self-help components, which are described in the self-help section. Professional treatment programs that

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[29] Kinney and Leaton, p. 226.

exist to provide treatment for alcoholism or drug dependence typically must be certified to do so by the State (NYS OASAS). They may include services such as:

Individual Counseling

This is a one-on-one series of meetings between a client and counselor. They work together to define problems and look at possible solutions. As they identify resources, the counselor provides support, encouragement, and feedback to the client as he/she takes action in his/her recovery. Very often, this includes planning and organizing what other types of treatment will be most helpful.[30]

Education

This can include reading materials, classes, or being part of individual counseling. There can be several goals for education such as:

-- increasing self-awareness
-- learning facts about alcoholism and other addictions
-- understanding that past behaviors have been "normal" symptoms of the disease
-- learning that abstinence from alcohol and/or drugs can change the behaviors that have caused so many problems in life
-- learning responsibility for one's actions
-- learning that recovery and prevention of addiction in subsequent generations is possible
-- learning that he/she is not alone, and that others have similar problems and feelings.

Sometimes the first step in helping people who are still denying that they have an alcohol or drug problem is education about the symptoms of the disease. Denial is such a powerful part of alcoholism and other addictions that unless people can identify their behaviors as being symptomatic of a disease, they continue to find endless excuses or situations to blame for their use of alcohol and drugs.

Learning that alcoholism and other addictions are not moral failures, but treatable diseases can also help alleviate the shame that keeps many alcohol and drug addicted people from seeking help. They also need to know that it is possible to live a normal life without the use of drugs and alcohol, something which has become an impossible idea for most of them.

Group Therapy

A very common type of treatment for alcohol- or drug-addicted persons is group therapy. It is often reported to be the most effective approach. In a small group led by a professional counselor, the recovering people are allowed the experience of being with other people that is very different from what they may have had in the past. Some of the positive changes that come from sharing problems and talking about feelings in a group are:

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[30] Kinney & Leaton, p. 226.

-- learning that other people can be a source of safety and strength
-- learning who you are, your capabilities, and your effect on other people
-- reducing the sense of isolation which is so familiar to most alcohol and drug addicted people
-- changing a negative self-image and finding out that you are not uniquely bad or an awful person[31]
-- learning about how alcohol and other drug addictions have similarly affected others in the group
-- becoming hopeful and believing that change is possible
-- learning about successful ways to live free from alcohol and other drugs
-- becoming more aware of feelings that may have been numb for a long time, and learning to express stifled feelings to others.

Children and Family Treatment

Alcohol or drug addiction affects everyone in the family. Treatment can help them even if the alcohol or drug addicted person is still using, gone, or dead. They can learn to live their own lives despite the active alcoholism or addiction. They need to know the facts about alcoholism and drug addiction, and learn how it is affecting them. Members of the family are usually doing whatever they can to deal with the family member with the problem. Family members often try to cover up for the behavior of the addicted person and arrange their lives around the addicted family member. These actions result in enabling the family member to continue to drink or use drugs without having to face the consequences of his/her behavior, as discussed earlier.

Family treatment is *not* treatment of the alcohol or drug addicted person. Rather, family members make changes in themselves which can, and often do, lead to treatment of the alcohol or drug addicted person. But it may not, and it's important that family members focus on their own needs and what they themselves can directly change.

Children are often left out of treatment by family members because parents believe that they are too young to understand or that they need to be protected. By not being involved in treatment, children can become even more frightened and isolated.[32] They often think that they caused the problem. Alcoholic parents may have blamed their children for "driving them crazy" and causing them to drink or use drugs. Children need to know that the alcoholism or drug addiction is never their fault.

Treatment Facilities

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[31] Kinney and Leaton, p. 237.

[32] Kinney and Leaton, p. 249.

For many people, recovery from drug addiction and/or alcoholism begins in some type of treatment facility. The early stages of withdrawal from chemical dependency can cause physical and emotional problems that may require professional help. Professional treatment facilities fall into one of the types described below.

Alcohol Crisis Centers
Formerly called "Sobering-Up Stations," these community-based programs provide a medically supervised environment for people who are intoxicated and need to "dry out." An Alcohol Crisis Center provides bed rest and proper nutrition under professional monitoring. The length of time in these centers can be one to five days, often followed by a referral to another treatment program.

Hospital Detoxification
Under medical supervision, 24-hour care is provided for patients who need to be hospitalized for alcohol or drug withdrawal. Hospital detoxification programs generally last from five to seven days. Many patients go on to some additional treatment following detoxification.

Inpatient Rehabilitation Programs
These are concentrated programs of alcohol and drug education combined with individual and group therapy which can last from three to eight weeks. Patients stay in a medically supported environment and participate in activities which are all aimed at recovery from alcohol or drug addiction. The physical, emotional, and spiritual aspects of a patient's recovery are addressed through the different types of treatment we've discussed. Education and counseling for family and friends are also available. These are usually staffed by a variety of kinds of professionals, in a multidisciplinary team.

After completion of a rehabilitation program, further services may be recommended in a half-way house, a full-time residence, a day treatment program, or an outpatient clinic to maintain recovery and prevent a relapse once back in the outside world. Becoming involved in Alcoholics Anonymous or Narcotics Anonymous is usually encouraged.

OASAS operates 13 public inpatient rehabilitation programs across the state. The locations are listed in the resource section of this module. There are also a wide variety of private, proprietary inpatient facilities in New York State. A referral number for further information is included in the resources section of this guide.

Outpatient Clinics
In an outpatient clinic, alcoholics and addicts obtain a full range of treatment services, from evaluation to full-day or evening programming. Staffed by professionals, most clinics are open from 9:00 am to 9:00 pm and on weekends. Services provided can include individual, group, and family therapy, and educational sessions covering topics related to recovery. The type of services for a particular client is usually planned by that client and his/her primary counselor. A specialized form of service in some outpatient settings is the administration and supervision of methadone, discussed earlier in this module as a tool used in recovery from heroin

addiction for either long-term methadone maintenance or to transition to abstinence.

Halfway Houses

These are secure home-like settings that are usually located in the community. They usually serve same sex clients, but may be co-ed. They provide a safe, drug-free and alcohol-free environment in which to continue the process of recovery. Professional staff and peer support, combined with outpatient clinic visits, are available. There are often social and recreational activities to help create a new drug and alcohol free lifestyle. The length of stay ranges from three to nine months depending on the recovering person's needs.

Therapeutic Communities

These are a longstanding form of treatment for drug addiction, using an inpatient setting often over a period of six months to a year or longer. They are characteristically known for involvement of previous graduates of the program as on-staff role models to new clients as an important part of overall treatment and long-term recovery. Transition to affiliated residences to continue to support recovery and be assisted with job placement is also common.

Residential Chemical Dependency for Youth

Treatment services are provided for young people, 12- to 18-years-old, in a home-like setting staffed by professional counselors. Short-term programs last from 6 to 8 weeks while longer term programs can be 6 to 15 months. Young people receive a highly structured and intensive treatment program followed by ongoing outpatient services. Family services are an important part of these programs.[33]

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[33] NYS Division of Alcoholism and Alcohol Abuse, *F.Y.I. Alcoholism Treatment Works*, 1992.

SELF-HELP PROGRAMS
(NON-PROFESSIONAL SUPPORT GROUPS)

Run entirely by and for members, there are a myriad of support groups now available worldwide. Much is beyond the scope of this section, which will introduce the topic and cover some basics. The most important thing to keep in mind is that the self-help programs have both similarities and differences. It's important to contact a group directly to learn what they offer, and how, for your own sake as well for the sake of its members, to connect with the most appropriate group in a way that is respectful of the needs of that group. This will allow you to correct any myths you may hold, and also find out which meetings are and are not open to you. Matching a particular program or meeting with your specific needs enhances your prospects for participation and recovery.

Formerly few in types, the recent explosion in support groups has added some different models: some for new audiences or addictions, some for different philosophical approaches such as secular or Christian-identified, etc. (See the resources section of the module for more information.) Many of the programs have their roots in the steps or the mutual self-help traditions of Alcoholics Anonymous, which has been referred to as the "granddaddy" of self-help groups around the world.

Alcoholics Anonymous (AA) has been described as "the single most effective treatment for alcoholism." It is difficult to paint a true picture of how AA works. The best way to learn is to attend meetings over a period of time, watching and talking with people in the process of recovery actively using the AA program. *However*, it's again important to first learn about which meetings are open (to nonalcoholic guests), versus those which are closed to all but members of the fellowship.

There are a number of self-help groups which provide support for family members of alcohol and drug addicted persons by following the original Alcoholics Anonymous model. Alcoholics Anonymous has also been the model to help people suffering from drug addiction, gambling addiction, and food addictions. All of these groups have in common the following:

-- There are no fees, although members may contribute what they can afford to help pay for expenses such as coffee and meeting space.

-- Each group is autonomous and not connected to any outside organizations such as churches or treatment facilities.

-- Groups are not led by professional counselors.

-- Persons who feel that they have a problem or want to learn more about alcoholism or other addictions may join.

-- The group members are there to help each other with common problems.

-- Most groups follow the 12 Steps of Alcoholics Anonymous for their recovery program (there are other self-help programs that do not, as indicated below).

-- All practice anonymity, meaning no one is identified outside of the "rooms" where the meetings are held, and only first names are used in the meetings.

Alanon is a support group for family members which helps them to live their own lives regardless of the actions of the alcoholic person about which they're concerned (spouse, close friend, etc.). They learn ways of changing themselves, and "detaching with love" from the addicted person. No promises are made that this will have any effect on the person using drugs or alcohol, but there are many cases where that person will enter treatment as a result of changes made by a nonusing spouse.

Alateen provides group support for teenagers with an alcoholic parent. Their problems are much different from those of a spouse, and they need to learn how to deal with them. These children often feel a sense of shame about their family and are afraid to talk about their problems and being "different." They learn that they are not unique and have much in common with kids from other families with an alcoholic parent.

Narcotics Anonymous (NA) is modeled after AA and serves people whose primary addiction is to drugs, including prescription medication. Often people attend meetings in both fellowships since abuse of drugs is often combined with alcohol.

Both AA and NA stress abstinence and believe that nothing can really change until a person stops drinking or using. In the process of stopping, many people actually change their whole way of life. Since their lives were centered around drinking and using, stopping means that a whole new range of behaviors must be substituted for the old way of life.

How the Self-Help Programs Work

The 12 Steps of AA and NA are the guide for this life changing process. The Steps grew out of the practical experience of the founders and earliest members of AA based on what they had done to gain sobriety. Originating in 1935 with a stockbroker and physician ("Bill W." and "Dr. Bob") and their struggles to recover and help each other, the steps are an action plan for change in a suggested program of recovery. Their effectiveness is attested to by the great number of recovering alcoholics, and by their adoption by Narcotics Anonymous and other groups such as Gamblers' Anonymous and Overeaters' Anonymous. (The appropriate addiction is substituted for the word alcohol in the materials).

An important part of the self-help fellowships is the tradition of anonymity. When persons attend an AA, NA, Alanon, or Alateen meeting they identify themselves only by first names. This helps newcomers, who may be suffering guilt, shame, and a sense of failure, give the program a chance while assuring them of complete confidentiality. Members do not discuss who attends the meetings. Some meetings end with the reminder that "Who you see here and what is said here, stays here."

Meetings are held on a daily basis in most areas, and several meetings a day are held in larger metropolitan areas. They usually last about an hour. All of the fellowships publish meeting lists which can be obtained at most treatment centers, or by calling the AA, NA, or

Alanon numbers listed in the telephone book, or any alcohol or drug abuse hotlines.

Meetings in both the AA and NA fellowships are divided into open and closed meetings. Open meetings can be attended by spouses, family, friends, and others interested in alcoholism, addiction, and recovery. Closed meetings can be attended only by alcoholic or drug addicted members. Open and closed meetings can be of two types: speaker or discussion meetings.

Speaker Meetings include one to three speakers who tell their stories to the rest of the group. Their stories usually include what their drinking and/or using was like and how it affected their lives; how they came into recovery; and what their experiences in recovery have been like. Speaker meetings are usually recommended for people first coming into the program who are still unsure about whether they have a problem with alcohol or addiction. Relating to someone else's experience is often the key to realizing that the AA or NA program may be what is needed to stop drinking or using substances.

Discussion Meetings are led by one of the members who may briefly tell his/her story, and then opens the meeting to a discussion of either a problem someone is experiencing, or working on one of the 12 steps. Topics are brought up by one to three people, and the rest of the meeting is open to sharing what other people's experience with the problem or step has been. Recovering alcoholics and addicts help each other in meetings by sharing experience, strength, and hope.

The now familiar slogans of AA such as "One day at a time," "Easy does it," and "Keep it simple" are brought up at meetings as reminders of how to work the program by changing old behaviors. Worrying about the future or obsessing about the past, making problems more complex, and trying to control everything in their lives are familiar behaviors for recovering people. The slogans are short reminders to try to change these behaviors. Though the slogans are simple, the changes they require are profound.

Recovery is considered a lifelong process which goes on before, during, and after meetings or other treatment settings. Other important aspects of AA include talking to a sponsor (someone with a longer recovery whose own experience can help); talking to other people in the fellowship on the phone (especially when the urge to drink or use comes up); and participating in social activities that may be sponsored by the fellowship (such as dances, picnics, or just getting together for a good time).

For most people, learning to have fun without the use of drugs or alcohol is an important part of recovery. There is a lot of work to maintaining sobriety and abstinence from drugs. But recovery is learning a whole new way of life, including good times and socializing with new friends who are not drinking or using.

Again, there are other self-help programs for alcohol and other drugs that are newer and of different designs. Since they are much newer, they are much fewer in number and not

available in as many areas as yet. They were formed to meet needs that members felt were not being addressed by other groups. They include Women for Sobriety, Secular Organizations for Sobriety, and Overcomers Outreach (for Christ-centered 12-step support groups). For specific information on contacting these and other support groups, please see the resources section.

RECOVERY

Most people think of recovery from alcoholism or drug abuse as an event that happens rather than as a lifelong process that can be interrupted or changed at any time. Abstinence from alcohol is only the first step in the recovery process. The disease of alcoholism develops over a long period of time; and true, meaningful recovery takes place throughout a person's entire life.

Recovery means learning to live without alcohol, as well as learning new skills to manage life as a sober person. Essential aspects of recovery are exploring sober value systems and developing an integrated and balanced way of life. This is not an easy process for anyone, much less for a person who has been using chemicals over a long period of time. New skills include:

- -- finding new ways of problem solving
- -- utilizing different kinds of reasoning
- -- developing effective thinking patterns
- -- cultivating an understanding of the self.

The alcoholic must grow and mature through several different phases of the recovery process. The family and significant others must undertake a similar process, and also strive to understand the recovery process for the alcoholic. According to Terrence Gorski and Merlene Miller, there are several stages of recovery which fall into the broader categories of early, middle, and late recovery. Each stage has specific tasks that must be accomplished in order to pass onto the next stage. These tasks start with acceptance and end with a strong maintenance plan for a daily program for ongoing recovery and personal growth. It is essential that the alcoholic person and the family recognize these stages and follow the necessary steps to accomplish them.

In spite of the best efforts of patients, families, and treatment professionals, recovery efforts often fail because all three groups are usually unaware of the long-term developmental phases of the recovery process. Alcoholics are generally unprepared or underprepared to successfully complete each phase of the process. No matter how hard they try, recovering alcoholics often fail and relapse. This aspect of alcoholism is *the* most neglected area of treatment and needs to be better understood by *all* if true meaningful recovery is to occur.

Relapse

Alcoholism is a chronic disease and as such does long-term neurological damage, creates long-term personality changes, and creates long-term lifestyle adjustments that follow the person into recovery. Unless ongoing personal inventory and personal growth are maintained, it is easy to lapse into old behaviors.

As recovery is a process, so is relapse a process. Although most people tend to view relapse

as an event of drinking, it is instead a process that can be changed or interrupted at any time. However, there cannot be intervention and change unless the alcoholic, the family, the treatment personnel, and others involved are familiar with the process and able to recognize its symptoms.

In the process of recovery, there are tasks in every stage that need to be accomplished. If the task is not accomplished, the client has difficulty in continuing his or her growth in the recovery process. People tend to get "stuck" at certain tasks, fail to accomplish the task, and growth is limited. Often it is at this stage that the recovery process stops and the relapse process begins. Thus, the first step in preventing relapse is a true understanding of recovery as a long-term program of change in:

-- identifying self-defeating personality styles
-- changing self-defeating personality styles
-- integrating a new, healthier style
-- leading a balanced life compatible with society
-- generating serenity and peace of mind
-- maintaining peace of mind.

Relapse symptoms and patterns in the alcoholic usually appear long before the first drink is taken. Studies have shown that these relapse symptoms are as objective and predictable as the symptoms of alcoholism. Many of these symptoms or patterns can act as warning signals to the alcoholic and the family. Warning signs begin with mild indicators such as a change in thought pattern, emotional process, and behavior. Symptoms are progressive and will increase in severity unless action by the patient or family interrupts the process.

Relapse symptoms develop slowly. A daily inventory of feelings and actions can help the alcoholic and family identify some of the warning signs early on in the relapse process. Once the alcoholic is well into the process of relapse, it is essentially impossible for him or her to stop the process without intervention from others. The alcoholic's thinking by this time has deteriorated into the pretreatment alcoholic rationalization and denial. Old lifestyle personality has kicked in to control behavior. This is why it's essential for families to be educated from the beginning so that they can recognize the symptoms early on. Only then can they intervene and help change the process.

<u>Warning Signs of Relapse</u>

There are typical warning signs of relapse. The following list is not all inclusive; and each person must, with professional help, learn to identify his or her own symptoms and triggers.

1) *Exhaustion*: Alcoholics should not allow themselves to become overly tired or fall into poor health. If you feel well, you are more apt to think well. If you feel tired and poorly, your thinking tends to deteriorate. If you feel badly enough, you might begin thinking that a drink could make it better.

2) *Impatience*: Thinking things are not happening as fast or as you want them to

3) *Self-pity*: "Why me" or "Nobody understands me"

4) *Complacency*: "I won't ever take another drink" or "I don't need AA" or "I don't even want a drink"

5) *Frustration*: Things are not going your way so you may begin to get frustrated more easily

6) *Cockiness*: "I don't need AA" or "I'm not afraid, it can't happen to me, I know what I'm doing"

7) *Boredom*

8) *Decreased interest* in AA, self inventory, or self-improvement

9) *Depression*

10) *Argumentativeness*: picking fights, arguing small or unimportant points

11) *Concentration on the negative* and forgetting gratitude.

12) Setting of *unrealistic goals*

13) *Omnipotence*: usually ignoring any advice and having all the answers

14) *Use of mood altering chemicals*: Thinking your problem is only with alcohol, and that pills could help you with your stress

15) *Dishonesty*: Starting with small lies and progressing to bigger ones.

True relapse prevention should be done over a long period of time in treatment by knowledgeable treatment providers. Relapse prone alcoholics need to be identified and receive individualized treatment concurrently with basic education on alcohol and alcoholism. It is only by first recognizing and then educating relapse prone alcoholics to reduce the shame and guilt associated with relapse that they will begin to lead fulfilling happier lives.

WHEN THE PROBLEM FEELS CLOSE TO HOME

This module has covered a wealth of material related to alcohol and other drugs, and this subject often stirs up powerful feelings and experiences and memories. You may feel some of these effects, so this section includes some ideas about addressing those feelings.

As a Person

You or your students may find that this material has prompted a reevaluation of personal experience with alcohol and drugs. Sometimes people become concerned about their own chemical use, their experiences during use, or how they have felt after using. Some will wonder if they need help, while others will be sure that they do. There are a variety of professionals and other resources that you can consult, anonymously if you wish, to find out more about your situation and what you can do. Pick the one that seems right for you, and give them a call. Don't worry alone.

As a Family Member/Significant Other

This material may trigger awareness of alcohol or other drug problems when you were growing up, in your current family, or in a close friend. It's important to get the support you need in sorting out your feelings and needs first, as well as in learning more about what does (and does not) help those affected.

As a Parent

Thankfully, there are now treatment programs and support groups for families and for young people, some of which are listed in the resource section. You do not have to tackle this alone. There are parents and children out there who have succeeded in dealing with alcohol and other drug problems who can help you do the same.

As an Employee

You may be wondering about how all this relates to your worksite. Is there an Employee Assistance Program (EAP) available to you where you can go or call for confidential advice and referral? What are the policies about alcohol and drug problems, recovery, and treatment? What about alcohol or drugs on the premises in the agency?

As a Teacher

You can be easily drawn into the burdens of a counseling role with your students and their families and friends, especially when the need seems so great. It helps to be clear about the actual expectations in your particular job, and what the limits and resources are. It can be such a relief to be able to turn to specialists in the area, and to refer students and family members to the people specifically trained to deal with the complexities of the alcohol and drug abuse system.

-- What kinds of situations have the other teachers in your setting been encountering?

-- What kinds of resource programs and materials are available to incorporate within your setting, without reinventing the wheel?

-- What kinds of resources are available in surrounding programs? Consider visiting them to get some ideas and support for your efforts.

A special note about issues to consider in inviting guest speakers to your program: it's very important to identify your specific goals in having such a speaker, and to then draw on your connections to learn about speakers who have worked well with colleagues or friends you know. It is very easy in this area to find enthusiastic speakers, but, at times, the speaker's emotions can result in a direction or message other than you intended. For instance:

-- Will the speaker emphasize all the ins and outs of active use, and indirectly and unintentionally glamorize it?

-- Will the speaker be inclined to moralize or preach, and alienate portions of your intended audience?

-- Will the speaker be very knowledgeable about the various drug issues, yet unable to communicate about them in plain language, in a balanced fashion?

You may find it very helpful to begin with your local council on alcoholism and drug addiction, school student assistance professionals, or a local treatment program to learn about some particularly effective speakers who can reliably enhance your efforts.

In Your Community

Recognize that you are not alone, and that you have insights and skills to bring to the efforts within your community. Some of the best intentioned education programs in this area have failed because of the absence of teaching expertise, or because the noneducators involved didn't first develop a feel for their "students." You can be invaluable in these areas as well as helping to network services useful to you and your students into programs. You *can* make a difference!

SAMPLE LESSON 1: TEST YOURSELF

Goal: To examine our own use of alcohol and other drugs.

Outcome Objective: Learners will take a self-test to determine whether or not they are at risk for alcohol or other drug dependency.

Instructional Materials & Resources: Handout A included in this guide.

Activities

Activity 1: Discuss with learners their use of alcohol and other drugs. Explain that although everyone is entitled to a "good time," if alcohol or other drugs are involved it should be done legally and safely. Not everyone is able to use chemicals without the risk of becoming addicted or dependent. Review the sections on "risks" in this guide to see how some individuals are more physiologically at risk than others.

Activity 2: Learners will complete Handout A, being as honest as possible. Ensure that the test is for themselves and completely confidential. Upon completion, explain that "yes" answers indicate warning signs for alcohol or other drug (chemical) dependency, but do not necessarily mean that a person is addicted. Recommend that students seek counseling if they feel they or someone they know may be at risk.

Please Note: Anytime people begin to face their use of alcohol and other drugs, the situation can be uncomfortable and/or threatening for them. It is important for instructors to emphasize that "yes" answers are warning signs, not definitive proof of an addiction. Instructors must also be aware of available resources for referral of clients.

SAMPLE LESSON 2: IT'S IN THE BLOOD

Goal: To realize the impact of alcohol's presence in the blood.

Outcome Objective: Learners will be able to compute the Blood Alcohol Concentration of individuals drinking various alcoholic beverages and describe the relative risks of alcohol consumption.

Instructional Materials & Resources: Handouts B^1, B^2, and B^3 included in this guide

Activities

Activity 1: Distribute the handouts and read the scenarios on Handout B^1 as a group activity. Students will then use the table on Handout B^2 to estimate the BAC of the characters.

Activity 2: Using Handout B^3, students will write brief paragraphs describing the possible consequences of the characters' actions.

SAMPLE LESSON 3: AN OUNCE OF PREVENTION . . .

Goal: To underscore the importance of prevention of alcohol and other drug problems.

Outcome Objective: Learners will develop a prevention campaign targeting various populations.

Instructional Materials & Resources: posterboard, paper, old magazines, scissors, glue, markers

Activities

Activity 1: Read through the section in this guide entitled *Specific Populations* on page 22. Discuss with the students those populations most relevant to them, and problems they may see within their populations. Learners will look through magazines to find advertisements targeted to their audiences.

Activity 2: Learners will use magazines and other materials to develop slogans, posters, and brochures to launch a prevention campaign against alcohol and other drug problems.

Activity 3: As a class, learners will plan a "grand finale" prevention presentation to which other classes would be invited. Learners can arrange for a recovering alcoholic or drug addict to speak to the group, and perhaps provide literature from various treatment programs.

SAMPLE LESSON 4: TO BE OR NOT TO BE LEGAL

Goal: To discuss politically sensitive drug and alcohol issues.

Outcome Objective: Learners will debate various issues in the classroom.

Activities

Activity 1: Discuss the fine lines government must draw between protecting the American population and unduly regulating people's lives. Today many people have different notions about what should and should not be legal. Two topics of controversy are the legalization of marijuana and programs that provide clean needles to addicts to attempt to prevent the spread of hepatitis, HIV, and other diseases.

Activity 2: Learners will research and discuss in depth issues of their choice (the number of issues debated will depend upon the size of the class and the time available). Divide the class according to what side of the issue they wish to argue. Learners can research their arguments at the library or via other available information.

Activity 3: Set up the classroom in mock debate style. Students will take turns presenting their sides of the argument.

SAMPLE LESSON 5: A LOOK AT MEDIA MESSAGES

Goal: To become aware of the role of media (including advertising and television) in shaping perceptions of alcohol and other drug use norms in society.

Outcome Objective: Learners will be able to identify and describe at least four specific examples of different media messages about the use of alcohol or other drugs, including two that encourage use and two that do not.

Instructional Materials & Resources:

--a guide to television program listings
--several current magazines, targeted to different consumer groups
--material by Jean Kilbourne

Activities

Activity 1: Learners form small groups which will focus on particular interest areas (e.g., prime time network TV; cable TV; women's magazines; men's magazines, etc.). Each group will carry out research of its choice during the week, keep a log of examples found, and bring in articles or videos (if possible) for display in class.

Activity 2: Learners will discuss the main types or themes of media messages they've encountered. Learners then predict where in the media each theme is most represented, and the groups who bring the strongest "proof" in the following class win.

Activity 3: Learners will identify a specific theme or message they would like to see more in the media, and plan a mock (or real) campaign to get their message into the public eye. For example, learners may develop jingles containing positive messages for television ads.

SAMPLE LESSON 6: ALCOHOL AND DRUGS IN THE NEIGHBORHOOD

Goal: To become aware of how the use of alcohol and drugs fits into a community as a whole, depending on the forces in each community at any given time.

Outcome Objective: Learners will describe the relationship between public alcohol/drug images and availability in two different neighborhoods.

Instructional Materials & Resources

-- an area map
-- student notebooks
-- if possible, a camera and film (still or video)

Activities

Activity 1: In small groups, learners will select at least two different neighborhoods of interest to study for each group. Learners will go out as active observers to notice what is in public view related to the use of alcohol and other drugs in each of these neighborhoods. They will then bring their reports back to the class.

Please note: Learners should be cautioned to conduct observations only in neighborhoods where they feel safe.

Activity 2: Learners will prepare a documentary for community education, either filmed/videotaped or made from collages from magazines, newspapers, etc.

Activity 3: Learners will discuss their findings and identify any patterns that may help to explain the differences found between neighborhoods. Groups can then brainstorm possible approaches for bringing about positive change.

SAMPLE LESSON 7: RECIPE CONTEST

Goal: To become aware of a variety of appetizing nonalcoholic beverages options.

Outcome Objective: Learners will be able to explain how to make at least two different types of nonalcoholic beverages.

Instructional Materials & Resources:

--standard mixed drink recipes
--magazines with pictures of drinks
--resource cookbooks
--assorted ingredients, bowls and cups (if possible)
--student imagination

Activities

Activity 1: Learners will bring in information about popular party beverages, including recipes, pictures, etc. In small groups, learners will discuss what types of beverage for which they would like to develop an alcohol-free option. Next, learners will review the recipes to see which ones would actually taste noticeably different without the alcohol.

Activity 2: Learners will research existing recipes, and bring the information to the next class. (Some possible sources include: the local library; the local council or treatment program; the local office of cooperative extension; fitness and weight loss magazines; local churches).

Activity 3: Learners will report to the class on their findings, and then vote on which two (or more) recipes the class would like to try. They will arrange to prepare and enjoy them in the next class.

Activity 4: Learners will create a alcohol-free beverage recipe book for themselves, their families, or for wider community use.

SAMPLE LESSON 8: MULTI-GENERATIONAL RECOVERY PANEL

Goal: To become aware that recovery, like addiction, can be multi-generational.

Outcome Objectives: Learners will be able to:

-- explain the relationship between recovery in one family member and the others in that family.

-- discuss the relationship between recovery in one or more family members and prevention for the next generation.

Instructional Materials & Resources:

-- one or more families with recovery established in two or more members of each family (The local council or treatment program can be a good starting place for a referral to you.)

-- printed materials on self-help groups in the community

Activities

Activity 1: In small groups, learners will discuss their own feelings on having a panel of recovering families, and what they think it might feel like for the panel members.

Activity 2: Learners will list some specific questions for the panel members. Questions may be given to the families ahead of time, at the panel, or both.

Activity 3: Learners will divide into small groups with a particular family member or two to talk further about the panel presentation and questions.

Activity 4: Learners will let the family members know what was especially helpful and likely to make a difference.

(**Note:** This can be a very effective way to learn about the various self-help programs and different experiences, depending on the family members involved. You may want to plan this within this panel, or have a self-help panel similar to that of Sample Lesson 9.)

SAMPLE LESSON 9: PREVENTION AND TREATMENT RESOURCES PANEL

Goal: To become aware of the kinds of services available in the community.

Outcome Objective: Learners will be able to identify and access a variety of treatment and prevention resources in their community.

Instructional Material & Resources:

-- representatives from a variety of prevention and treatment resources
-- printed brochures, business cards, admission information, etc. from these and perhaps other services

Activities

Activity 1: Learners will identify in advance the kinds of services they are most interested in learning about.

Activity 2: Learners will host a structured panel presentation, with an opportunity for questions and answers for learners.

Activity 3: In the next class, learners will discuss what they learned, identify any gaps in service, and identify any advocacy steps they may wish to take either as individuals or as a group.

HANDOUT A: ARE YOU CHEMICALLY DEPENDENT?

To answer this question, ask yourself the following questions and answer them as honestly as you can.

	Yes	No
1. Do you lose time from school or work due to drinking/using?	■	■
2. Is using or drinking making your home life unhappy?	■	■
3. Do you drink/use because you are shy with other people?	■	■
4. Is drinking or using affecting your reputation?	■	■
5. Have you ever felt remorse after drinking or using?	■	■
6. Have you gotten into financial difficulties?	■	■
7. Does your drinking/drugging make you disrespectful or defiant?	■	■
8. Has your ambition decreased?	■	■
9. Have your grades or work performance dropped?	■	■
10. Have you dropped out of athletic or social activities?	■	■
11. Have you ever been suspended or expelled from school, or formally reprimanded on the job?	■	■
12. Do you "party" two to three times per month?	■	■
13. Is drinking/drugging jeopardizing your job?	■	■
14. Do you lie to your family about where you go and with whom you spend time?	■	■
15. Do you drink/drug to escape from worries or trouble?	■	■
16. Have you ever had a complete loss of memory as a result of drinking or using?	■	■
17. Have you had accidents or near misses?	■	■
18. Have you ever taken prescription drugs without medical reasons?	■	■
19. Do you drink or use to build up your self-confidence?	■	■
20. Have you ever been to a hospital or institution on account of drinking/using?	■	■

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HANDOUT B[1]: THE ALCOHOL SCENES

Scenario #1 *After drinking her last two cans of beer one Friday night, Maria leaves her three-year old daughter at home alone "for just a minute" to buy some more beer at the store. On her way into the store, she bumps into an old friend who asks her to join him for a drink at the bar next door. She has a glass of wine at the bar, and then invites her friend over to her house. On the way to her car, she stops in at the grocery store to buy beer. Even though she has not eaten since breakfast and has very little food or milk for her daughter, she spends all of the cash she has left from her public assistance on beer because she knows her friend likes it.*

-- How will the alcohol, both the two cans of beer and the glass of wine, affect Maria?

-- If Maria weighs about 110 pounds, what might be her BAC? Should she drive home?

-- What are the consequences of Maria's actions, both for Maria and for her daughter?

-- What are some other choices Maria could have made?

Scenario #2 *Joe has dinner with his parents every Monday night after a long day of construction work. Often, he has a few beers with his dad while they watch football on TV. Joe's father is alcoholic, and likes company when he drinks, so Joe feels obliged to "keep up" even though he is tired. He splits a 12-pack with his dad in about two hours. Joe weighs about 180 pounds. He was stopped for drunk driving about five months ago.*

-- How will the alcohol affect Joe?

-- What might his BAC be? Should he drive home?

-- What could be the consequences of his actions?

-- What else could Joe have done?

Scenario #3 *John is an alcoholic person. He weighs about 140 pounds, and feels he can "handle" his liquor. He was stopped for drunk driving about five years ago, and lost his license for a year. Wednesday nights he bowls with a group of friends, and usually knocks off a few vodka-tonics. Tonight he has had four drinks within two hours.*

-- Should he drive home? What might his BAC be?

-- What could be the consequences of his actions?

-- What advice would you give John?

HANDOUT B[2]

DRINKING DURING A TWO-HOUR PERIOD[34]

Weight lbs./Kg.	No. of Drinks Consumed	Blood Alcohol Concentration (BAC)	Offenses
100/45	4	.10	DWI
140/64	5	.10	DWI
180/82	6	.10	DWI

A 12-ounce (360 ml) can of beer, a 5-ounce (150 ml) glass of wine, or a shot of 86-proof liquor all contain about the same amount of alcohol.
Note: BAC levels are estimates.

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[34] *You and the Drinking Driving Laws*, New York State Department of Motor Vehicles, 1993.

HANDOUT B[3]: THE PENALTIES

DRIVING WHILE ABILITY IMPAIRED (DWAI)
(more than .05 up to .09 blood alcohol concentration level)

	FINE	JAIL SENTENCE	LICENSE ACTION
First conviction	Minimum $300 Maximum $500	Up to 15 days	90-day suspension
Second conviction within 5 years	Minimum $500 Maximum $750	Up to 30 days	Minimum of 6-month revocation[1]
Third conviction within 10 years	Minimum $750 Maximum $1000	Up to 180 days	Minimum of 6-month revocation. (If current violation occurred within 5 yrs. of previous violation.)[1]

DRIVING WHILE INTOXICATED (DWI)
(.10 and over blood alcohol concentration level)

	FINE	JAIL SENTENCE	LICENSE ACTION
First conviction	Minimum $500 Maximum $1000	Up to 1 year	Minimum of 6-month revocation[2]
Second conviction within 10 years	Minimum $1000 Maximum $5000	As provided by penal law	Minimum of 1-year revocation
Second conviction involving personal injury or death	Minimum $1000 Maximum $5000	As provided by penal law	Lifetime revocation

[1]The Department of Motor Vehicles decides when the license will be returned. It is not automatic. You must reapply and be tested.

NOTE: Penalties for Commercial Motor Vehicle Drivers May be Greater. Fines are those in effect as of 11/1/92.

(Adapted from *You and the Drinking Driving Laws*, New York State Department of Motor Vehicles, 1993.)

RESOURCES

Alcoholics Anonymous
Grand Central Station
New York, NY 10163
(212) 870-3400
(For local programs, see your telephone directory)

American Society of Addiction Medicine
12 West 21st Street
New York, NY 10010
(212) 206-6770

Center for Health Promotion and Education
Centers for Disease Control
1600 Clifton Road
Atlanta, GA 30333
(404) 639-3311

Children of Alcoholics Foundation, Inc.
540 Madison Avenue
New York, NY 10022
(212) 754-0656

CompCare Publishers
2415 Annapolis Lane
Minneapolis, MN 55441
(612) 559-4800

Councils on Alcohol and Other Drug Dependence
Check local phone book listings

D.A.R.E. Program
Check local phone book listings or refer to your school district

"Drug Free Schools"
New York State Education Department

Hazelden Educational Materials
15251 Pleasant Valley Road, Box 176
Center City, MN 55012
(612) 257-4010

Johnson Institute
7151 Metro Boulevard, #250
Minneapolis, MN 55439-2122
(800) 231-5165

Mothers Against Drunk Driving (MADD)
National Office
511 East John Carpenter's Freeway #700
Irving, TX 75062-8187
(214) 744-6233

National Clearinghouse for Alcohol and Drug Information
PO Box 2345
Rockville, MD 20852
(301) 468-2600
(This is a good starting point in the national arena: offers free computer searches, audiovisual loans, and other resources, including the "Prevention Pipeline" newsletter.)

National Council on Alcoholism and Drug Dependence
12 West 21st Street
New York, NY 10010
(212) 206-6770

National Nurses Society on Addictions
Orchard Road, First Floor
Skokie, IL 60077-1024
(202) 625-8410

New York State Office of Alcoholism and Substance Abuse Services*
194 Washington Avenue
Albany NY 12210
(518) 473-3460
(* The state agency overseeing alcohol and drug prevention, intervention, and treatment. Formerly the Division of Alcoholism and Alcohol Abuse [DAAA] and the Division of Substance Abuse Services (DSAS), it includes a variety of resources, printed materials, and film library. It is also a source for the popular "Safe Summer" program for communities.)

Students Against Drunk Driving (SADD)
(Refer to you local school district for information)

Self-Help Organizations
(For local programs, look under "Alcoholism Information & Treatment Centers" or "Drug Abuse & Addiction - Information & Treatment" in the yellow pages of your telephone directory.)

Wisconsin Clearinghouse for Alcohol and Other Drug Information
PO Box 1468, Department E1
Madison, WI 53701-1468
(608) 263-2797
(608) 262-6243
(A particularly helpful catalogue source of video and printed materials for use in schools.)

New York State Office of Alcoholism and Substance Abuse Services (OASAS)
Public Inpatient Rehabilitation Services

Central New York
McPike
1213 Court St.
Utica, NY 13502
(315)797-6800, ext. 4801
Dir: John Robertston

Long Island
Charles K. Post
Pilgrim Psychiatric Center
Building #1
West Brentwood, NY 11717
(516) 434-7200
Dir: Phillip Dawes

Mid-Hudson
Middletown
P.O. Box 1453
141 Monhagen Ave.
Middletown, NY 10940
(914) 342-5511, ext. 3174
Dir: Richard Ward

Russell E. Blaisdell
Rockland Psychiatric Center
Building #28
Orangeburg, NY 10962
(914) 359-8500, ext. 3722
Dir: Louis Brandes

Finger Lakes
Dick Van Dyke
Willard Psychiatric Center
Building #112
Willard, NY 14588
(607) 869-3111, ext 2306
Dir: John Cole

John L. Norris
Rochester Psychiatric Center
Building #1
1600 South Ave.
Rochester, NY 14620
(716) 461-0410
Dir: Thomas Nightengale

North Country
St. Lawrence
Station A-Hamilton Hall
Ogdensburg, NY 13669
(315) 393-1180
Dir: Phillip Dranger

Western New York
Margaret A. Stutzman
360 Forest Ave.
Buffalo, NY 14213
(716) 882-4900
Dir: Steven Schwartz

New York City

Bronx Psychiatric Center
Building # 1
1500 Waters Place
Bronx NY 10461
(718) 931-0600
Dir: Ronald Lonesome

Creedmoor Psychiatric Center
Building # 19
80-45 Winchester Boulevard
Queens Village NY 11427
(718) 464-7500, ext. 7794
Dir: Jose Sarabia

Kingsboro Methodist Hospital
506 Sixth St
PO Box 159008
Brooklyn NY 11215-59008
(718) 965-7460
Dir: Jacqueline Cole

South Beach Psychiatric Center
Building A
777 Seaview Avenue
Staten Island NY 10305
(718) 667-4219
Dir: Gerlando Verruso

Manhattan
Building # 105
600 East 125 St - Ward's Island
New York NY 10035
(212) 369-0500, ext. 2400
Dir: Katherine Santiago Vazquez

Print Resources

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APPENDIX A: TRANQUILIZERS

What it is:
Names: Tranks, downers, antianxiety agents (anxiolytics), happy pills, BZDs, mood modifiers, mood elevators.

MINOR TRANQUILIZERS

Benzodiazepines I: Alprazolam (Xanax), chlorazepate (Tranxene), chlordiazepoxide (Librium, Novopoxide), diazepam (E.Pam, Valium, Vivol), lorazepam (Ativan), oxazepam (Serax) Vs (Valium).
Benzodiazepines II: Flurazepam (Dalmane, Novoflupam, Somnol), nitrazepam (Mogadon), temazepam (Restoril), triazolam (Halcion).
Meprobamate: Equanil, Meprospan-400, Miltown.
Forms: Bezodianzepines I - white, creamy or yellow powder, crystalline or fine. Benzodianzepines II - white or yellow crystalline powder. Meprobamate - white powder. Soluble in varying degrees with water and/or alcohol.
Combinations: Librax (chlordiazepoxide, clidinium bromide) for peptic ulcer, 217 Mep (meprobamate, ASA, caffeine citrate), 282 Mep (217 Mep plus codeine phosphate). When abused, combined with other central nervous system depressants, especially alcohol and barbiturates.
Usage: Swallowed as capsule, tablet or liquid. Injected into bloodstream as solution.
Legal Status: Legal as manufactured and prescribed.
Other Forms: Major tranquilizers are used in managing psychiatric illness. Unlike minor tranquilizers, their effects do not mirror sedative/hypnotic drugs. Combined with alcohol and other depressants, however, side effects are intensified.

What it feels like:
Relaxation and calmness (mild euphoria with diazepam, more intense with meprobamate), drowsiness, fatigue, hostility, dizziness, depression, blurred and double vision, confusion, memory loss, hallucinations.

What it does:
To Your Mind: Activates specific brain receptors.
To Your Body: Interferes with control of movements.
Special Characteristics: Diazepam is often substituted for methaqualone (ludes, 714s, Quaalude) when sold on the street. Small amounts of alcohol can be lethal when interacting with benzodiazepines. Heroin addicts and recovering alcoholics use Diazepam to achieve mild intoxication. Benzodiazepines can alleviate side effects of withdrawal from other drug abuse.

How it can hurt you:
Lack of coordination. Altered speech, confusion, coma. Withdrawal effects. Tremors, altered speech, rapid heart rate, blood pressure drop, headache. Mood swings, tension, nightmares, nausea, rash. Loss of sexual function, apathy, increased toxic effects in combination with

other CNS depressant drugs.

Death from effects of combinations of tranquilizers and other drugs such as alcohol, or from driving under the influence.

When to get help:
Do you find it hart to cope without a pill?
Is your work or school performance affected by your drug use?
Are you having problems with family and friends?
Do you use a variety of drugs?

One "yes" and your common sense knows it's time to get smart about drugs and the rest of your life.

Fact: Tranquilizers are the most widely prescribed psychotherapeutic agents in the world, and are most involved in suicide attempts and accidental overdoses.

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APPENDIX B: DOWNERS/BARBITURATES

What it is:
Names: Barbiturates, barbs, downers, goofballs, Amytal (amobarbital), Butisol (butabarbitral), Nembutal (pentobarbital), Luminal (phenobarbital), Seconal (secobarbital), methaqualone (ludes, 714s).
Type: Sedative, hypnotic.
Forms: White, bitter tasting powders soluble in water.
Combinations: With amobarbital and secobarbital, "Tuinal" with butalbital, ASA (Aspirin), and caffeine, "Fiorinal" (with codeine, "Fiorinal C") with weak street heroin and methamphetamine.
Usage: Swallowed as tablet, capsule or liquid solution.
Inserted as rectal suppository.
Injected into bloodstream (mainlining) or muscle, or under skin (skin popping).
Legal Status: Legal as manufactured and prescribed by license for clinical use.
Other Forms: Similar acting non-barbiturate downers once sold as Quaalude or Mandrox are no longer manufactured in America.

What it feels like:
Relaxation, peacefulness, sleepiness, pleasurable intoxication, dizziness, inactivity, withdrawal, interrupted thought processes, mood swing, excitement, increased pain, hostility, depression, anxiety, confusion, changed vision, increased sex drive, intense emotions, hangover.

What it does:
To Your Mind: Depresses central nervous system.
To Your Body: Progressive decline in blood pressure, heart rate and breathing. Nausea, vomiting, abdominal pain. Alternate pupil constriction and dilation. Loss of reflex response. Low body temperature and blood temperature. Weak pulse.
Special Characteristics: Effects cause ever increasing depression of respiratory control centers of the brain. Medical application is based on the durations of action of the many and various barbiturates: ultra short, short and intermediate, long acting. Tolerance leads to increased doses, risk of life-threatening complications, and severe withdrawal symptoms.

How it can hurt you:
Anxiety, restlessness, depression. Psychotic episodes. Impaired memory, judgment and thinking. Worsening of preexisting emotional disorders. Hostility, chronic fatigue from sleep disturbance or insomnia. Slurred speech, limited motor coordination. Changes in eyesight. Vertigo, impotence, reduced sex drive, irregular menstruation, breathing disorders.

Death can come from stopped breathing, suicide, combination with other CNS depressants (such as alcohol), severe withdrawal reactions.

Dependence builds with tolerance, which varies for each individual, and develops as cross-tolerance to similar drugs. Craving continues after pleasurable effects disappear and drug use

is stopped.

When to get help:
Do you use downers regularly?
Do you think about how and when you're going to use them again?
Is your work or school performance affected?
Are you having problems with family and friends?
Are you spending more on drugs than you can afford?
Do you use other drugs in addition to barbiturates?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: Barbiturates are among the most dangerous, life threatening drugs.

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APPENDIX C: NARCOTICS

What it is:
Names: Codeine (schoolboy), heroin (junk, horse, H, Harry, scat, smack, scag, brown sugar), hydromorphone (Dilaudid), merperidine (Demerol), methadone, morphine, oxycodone (Percodan), pentazocine (Talwin), propoxyphene (Darvon), diphenoxylate (Lomotil), fentanyls, hydrocodone, (Novahistex DH), levallorphan (Lorfan), MPPP, opium, pain killers.
Type: Narcotic analgesic as natural or semisynthetic opiate. Synthetic opioids.
Forms: Poppy juice, powder, solution.
Combinations: With cocaine or methamphetamine (speedball).
Usage: Injected into bloodstream (mainlining, hit) or muscle, or under skin (skin popping). Swallowed.
Legal Status: Illegal except as manufactured and prescribed by license.
Other Forms: Narcotic combination compounds (ASA [Aspirin] and oxycodone or codeine) are used for moderate pain from inflammation. Morphine, codeine, and hydrocodone are used in cough suppressants. Morphine, opium and diphenoxylate (Lomotil) are used to relieve pain and for anesthesia.

What it feels like:
Orgasmic rush of pleasure, numbness, lack of pain, euphoria. Anxiety, depression, nausea, constipation may occur as after effects.

What it does:
To Your Mind: Depresses breathing and other brain centers. Relieves pain and anxiety.
To Your Body: Depresses all body systems.
Special Characteristics: "Antagonists" such as methadone prevent narcotic effects from developing and reverse the acute effects. Sharp, localized pain is not relieved well by narcotic analgesics. Withdrawal effects for all narcotics, and for methadone, can be severe.

How it can hurt you:
Impurity of street drugs, dangers of needle use (including infection and AIDS), withdrawal effects, limited vision, reduced sex drive, menstrual irregularity, chronic constipation, mood swings, breathing problems, heart problems, tremors, muscle twitches, hyperactive reflexes, nervousness, restlessness, seizures, toxic psychosis.

Death from malnutrition, overdose, combination effect of barbiturates and other sedative/hypnotic drugs.

Dependence develops with tolerance and cross-tolerance of other drug effects, and fear of withdrawal.

Unborn children of dependent mothers absorb the drugs and experience a life-threatening withdrawal process after birth. Methadone infant withdrawal is especially severe.

When to get help:
Do you think about how and when you're going to take drugs again?
Is your work or school performance affected?
Has your health changed?
Are you having problems with family and friends?
Are you spending more on narcotics than you can afford?
Do you use a variety of drugs?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: All narcotics are addicting and dangerous.

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APPENDIX D: SPEED/AMPHETAMINES

What it is:
Names: Amphetamine, speed, methamphetamine, bennies, black beauties, copilots, crystal, dexies, eye openers, lid poppers, meth, pep pills, uppers, wake-ups, Dexedrine, Desoxyn.
Type: Central nervous system stimulant.
Forms: White crystalline powder, soluble in water, slightly soluble in alcohol. (Methamphetamine is freely soluble in water and alcohol.) Off-white to yellow coarse powder, crystals, and chunks. Capsules or tablets of various colors.
Combinations: With barbiturates, "goofballs" with methamphetamine or cocaine and heroin, "spitballs" with LSD and PCP.
Usage: Swallowed (capsules, tablets).
Injected into bloodstream (solution).
Sniffed (powder), "snorted."
Legal Status: Illegal except for licensed medical treatment of narcolepsy, childhood behavior disorders, parkinsonism, epilepsy, hypotensive states.

What it feels like:
Rush of pleasure similar to orgasm or electric shock (after injection). Reduced appetite. Increased alertness, euphoria, excitement, creativity, power. Altered sex drive. Restlessness, dizziness, confusion, depression, irritability. Paranoia, distorted perceptions, visions.

What it does:
To Your Mind: Overstimulates central nervous system.
To Your Body: Increases heart rate, breathing rate.
Effects irregular heartbeat and breathing. Dry mouth, foul taste, diarrhea.
Appetite suppression. Retraction of gum tissue. Impotence. Increased urine output, fainting, sweating, fever, convulsions, coma, hemorrhage.
Special Characteristics: Methamphetamine "run" of three to five days produces euphoria replaced by agitation on second day, along with frightening visual images and exhaustion. Amphetamine "run" psychosis may bring on uncontrollable violet behavior similar to paranoid schizophrenia.

How it can hurt you:
Chronic sleep problems, nervousness. Nutritional deficiency, skin rash, high blood pressure. Paranoia, chronic amphetamine psychosis, decreased emotional control, severe depression. Needle related hepatitis, infection, Acquired Immune Deficiency Syndrome (AIDS), collapsed and blocked blood vessels, overwork of body systems.

Death from suicide induced by psychic depression, collapse of blood vessels in brain, heart failure, extreme fever, violent accidents and murders.

Dependence arises from tolerance and cross-tolerance, and taking additional drug to stop withdrawal effects, risking return of psychosis.

When to get help:
Do you use speed regularly?
Do you think about how and when you're going to use speed again?
Is your work or school performance affected by your drug use?
Are you having problems with family and friends?
Do you spend more on speed than you can afford?
Do you use drugs in addition to amphetamines?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: Speed users reach a plateau where no pleasure is possible.

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APPENDIX E: COCAINE

What it is:
Names: Cocaine, rock cocaine, coke, "C," flake, snow, stardust, Peruvian marching powder, the devil's dandruff.
Type: Central nervous system stimulant.
Forms: Leaf of coca bush (ritual form).
White crystalline powder as cocaine hydrochloride.
Vapor as cocaine freebase.
Dried lump of combined baking soda or ammonia and cocaine processed as freebase "crack" or "rock."
Solution diluted in water.
Combinations: With heroin, "dynamite," "speedball, " or "whiz-bang."
With morphine, also "whizbang."
Dissolved in liquid and drunk.
Usage: Chewed (leaves).
Smoked (paste and freebase lumps).
Sniffed or "snorted" into mucous membranes or nose (powder and vapor).
Applied to mucous membranes of mouth, vagina, rectum (powder).
Injected into bloodstream (in a water solution).
Legal Status: Illegal unless used by licensed physician as a local anesthetic. Also used in Brompton's cocktail to treat terminal cancer patients.

What it feels like:
Orgasmic "rush," then energetic, alert, with no need for food or sleep, talkative or peaceful, self-confident, in command, quick, agitated, anxious, unhappy.

What it does:
To Your Mind: Stimulates rapid, intense general euphoria.
To Your Body: Slows, then increases heart rate and blood pressure, constricts blood vessels, increases breathing rate, dries mouth, dilates pupils, exaggerates movements.
Special Characteristics: A cocaine "spree" may lead to a "crash" 'with severe depression, lethargy, hunger. Freebasing results in severe burn accidents.

How it can hurt you:
Shaking, muscle twitches, seizures, severe anxiety, compulsive repetition of movements. Paranoia, psychosis, heart related effects, nausea and vomiting. Changes in breathing, increase in body temperature, cold sweat, dramatic mood swings. Hallucinations, sensation of insects crawling under skin and other continuing psychotic effects. Eating and sleeping disorders, impaired sexual performance, destruction of nose tissue, ongoing respiratory problems, needle infections such as endocarditis, hepatitis, and AIDS.

Death from overdose and heroin combination, suicide, homicide, fatal accidents while under the influence. Snorting can be fatal.

When to get help:
Do you use cocaine regularly?
Do you freebase or inject cocaine?
Do you use it in the morning or at regular intervals?
Do you lie about how much cocaine you use?
Are you spending more on crack than you can afford?
Are you having problems at work or school or with family and friends?
Do you try to "buy" friendship or companionship with cocaine?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: Cocaine may be the most addictive drug of all for everyone.

Reproduced with permission from: *Comprehensive Addiction Treatment Services*, Falls Church, VA.

APPENDIX F: CRACK COCAINE

What it is:
Names: Crack, rock, "readyrock," "french fries" (three inch sticks).
Type: Central nervous system stimulant.
Form: Dried chunk or shaving of cocaine combined with baking soda or ammonia in water. A freebase form less pure than freebase prepared with ether.
Usage: Smoked as a vapor.
Legal Status: Illegal.
Other Forms: Leaf of coca bush (ritual form).
White crystalline powder or lump ("rock") as cocaine hydrochloride.
Vapor as cocaine freebase.
Solution diluted in water.
For medicinal purposes, used in solution as a surface anesthesia.
Combinations: With heroin, "dynamite," "speedball," or "whiz bang." With morphine, also "whiz-bang."

What it feels like:
Immediate and overwhelming high or euphoria lasting three to five minutes, followed by intense low with depression, worry, inability to concentrate.

What it does:
To Your Mind: Stimulates intense alertness and excitement.
To Your Body: Speeds up all systems, increasing heart rate and blood pressure, constricts blood vessels, alters breathing, creates dry mouth, dilates pupils, exaggerates movements.
Special Characteristics: Increased risk of overdose due to uncontrollable, higher concentration in bloodstream. Increased risk of heart failure in otherwise healthy users. Severe breathing and lung effects. Liver damage, malnutrition, overstimulation of all body systems, destruction of brain neurotransmitters.

How it can hurt you:
Shaking, muscle twitches, seizures, severe anxiety, compulsive repetition of actions with no meaning. Paranoia, psychosis, heart related effects, nausea and vomiting, changes in breathing, increase in body temperature. Cold sweat, dramatic mood swings, hallucinations, sensation of insects crawling under skin and other continuing psychotic effects. Eating and sleeping disorders, impaired sexual performance. Extreme social problems can develop from irritability, depression, and financial difficulties.

Death from overdose is common, as are suicide, homicide, fatal accidents while under the influence. Snorting can be fatal in itself. Breathing is often stopped when combined doses of cocaine and heroin are taken. Lethal doses vary by individual and are not predictable.

Dependence occurs as a psychological craving and physical withdrawal process. Unlike other drugs, intense psychological dependence is developed with even occasional low doses.

Street purchases are commonly substituted or diluted drugs. The unsuspecting buyer risks having no knowledge of what he or she is taking or what the effects may be.

When to get help:
Do you use crack?
Do you use it in the morning or at regular intervals?
Do you think about crack often?
Do you lie about how much you use?
Are you spending more on crack than you can afford?
Are you having problems at work, school, with family and friends?

One "yes" and your common sense knows it's time to get smart about drugs and the rest of your life.

Fact: Cocaine may be the most addictive drug of all for everyone.

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APPENDIX G: MARIJUANA

What it is:
Names: Cannabis sativa, hashish, hashish oil, marijuana, Mary Jane, Acapulco Gold, ace, bhang, Colombian, ganja, grass, hemp, Indian, Jamaican, jive, joint, Mexican, Maui wowie, Panama red, Panama Gold, pot, reefer, ragweed, sativa, sinse, tea, Thai sticks, weed, roach, hash, hash oil, honey oil, weed oil.
Type: Hallucinogen.
Forms: Grey-green to green-brown dry leaf, resin oil, leaf oil.
Combinations: With PCP, "supergrass," "killer weed;" with opium, "OJ;" with heroin, "atom bomb," "A Bomb."
Usage: Inhaling by smoking a "joint," bong or pipe. May be cooked or baked in foods and eaten.
Legal Status: Illegal.
Other Forms: The prime psychoactive element of cannabis, Tetrahydrocannabinol (THC), is administered in gelatin capsules for medical research testing of nausea treatment related to cancer chemotherapy, glaucoma, epilepsy and muscle spasm due to multiple sclerosis or spinal cord injury.

What it feels like:
Feelings of contentment and relaxation may be accompanied by loss of inhibition, bouts of laughter, continuous talking, increased sensitivity to audio and visual effects, increased sensitivity of touch, smell, taste and movement. Confusion, disorientation, recent memory loss, reduced attention span, lack of balance and stability, loss of muscle strength, shaking, anxiety, and paranoia may occur with higher dosages.

What it does:
To your mind: Distorts perceptions of reality.
To your body: Increases heart rate, lowers blood pressure, limits control of movement.

How it can hurt you:
Heart related effects. Asthma, bronchitis, damage to respiratory system and tissue. Reddening of eyes, change in sex drive, infertility. Changes in body temperature, hallucinations, slowed reaction time. Delusions, panic, toxic psychosis, activation of latent schizophrenia which may continue indefinitely. Amotivational syndrome, memory loss with possible permanent brain damage.

Death of self and others due to driving under the influence, especially when combined with alcohol.

Dependence can develop as a psychological craving.

Unborn children of mothers who use cannabis may develop congenital defects or experience delayed development after birth.

When to get help:
Do you think about how and when you're going to smoke again?
Do you worry if no marijuana is available?
Is your job or school performance affected?
Do you spend more and more money on pot?
Have you been stopped for driving under the influence?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: Cannabis is the most abused psychoactive drug by students, after alcohol.

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PCP/ANGEL DUST

What it is:
Names: Phencyclidine, PCP, peace pill, angel dust, crystal, hog, horse tranquilizer, tic, zoot.
Type: Dissociative anesthetic.
Forms: White, crystalline powder (may be colored as sold on the street), soluble in water or alcohol, pills or capsules.
Combinations: With LSD, with marijuana, tobacco, or parsley as "supergrass," "killer weed."
Usage: Swallowed as liquid, tablet, capsule.
Sniffed as powder, "snorted."
Smoked as sprinkle for marijuana or parsley (joints), tobacco (sherms), mint.
Injected into bloodstream.
Legal Status: Illegal. (Discontinued veterinary use.)

What it feels like:
Unpredictable. Various sensations including dissociation from the environment, euphoria, hallucinations, relaxation, distorted time, space and body sensations, feelings of floating and weightlessness, inability to think or concentrate, anxiety, paranoia, various auditory and visual experiences, as with LSD.

What it does:
To your mind: Depresses and stimulates central nervous system.
To your body: Alters speech, coordination, dexterity, and vision. Induces dizziness and drowsiness. Increases heart rate, blood pressure, breathing rate, urinary output. Induces sweating and vomiting. Causes jerky eye movement that can last for months after a single dose.
Special characteristics: PCP is often sold as a substitute for other drugs, causing panic in unsuspecting users.

How it can hurt you:
Loss of sense of pain, psychic experiences, states of panic and fear of death lasting for several days. Bizarre, compulsive and violent behavior, involuntary eye movement, rigid muscles, loss of gag and corneal reflexes. Arching of the body, coma, alternating high and low blood pressure, irregular heartbeat, irregular breathing, severe nausea and vomiting, alternating high and low body temperature. Loss of memory and thought processes, ongoing speech problems, depression, toxic psychosis as aggressive and assaultive behavior, hallucinations.

Death from stopped breathing, convulsions, brain hemorrhage, kidney failure, drug combinations, fatal accidents. Murder, suicide, self mutilation, and drowning from swimming under the influence to enhance floating sensation.

Dependence arises as tolerance develops. Use is often in "runs" of two or three days, with disorientation and depression after withdrawal.

When to get help:
Do you use PCP at all?
Do you think about how and when you're going to use PCP again?
Is your work or school performance affected by your drug use?
Are you having problems with family and friends?
Do you spend more on PCP than you can afford?
Do you use other drugs in addition to PCP?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: Even in low doses, PCP produces harmful psychological effects. One dose may produce physical effects that last for months.

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APPENDIX I: INHALANTS

What it is:
Names: Solvents, aerosols, nitrites (poppers), nitrous oxide (giggle gas, whippets), trichloroethane, sniff.
Type: Sedative/hypnotic anesthetic.
Forms: Hydrocarbon solvents as liquid or gas.
Combinations: Anti-freeze, gasoline, de-greaser. Windshield washers, foam dispensers, acetone. Cleaning fluid, spot remover or shoe polish, nail polish remover. Gasoline, household cements, lacquer thinners, lighter fluid, model cements. Airplane glue, plastic cements, rubber tire patching cement. Paint, and varnish removers, paint brush cleaners, household waxes. Typewriter correcting fluids and thinners, general household cleaners. Floor wax removers, suede cleaners, liquid incense, room deodorizer.
Usage: Inhaling gas or vapor from balloon, paper or plastic bag.
Sniffing vapor directly from container.
Inhaling saturated material placed over mouth.
Heating and inhaling higher vapor concentrations.
Swallowing solvent mixed with alcoholic beverages.
Injecting into bloodstream.
Spraying aerosols directly into mouth.
Legal Status: Legal. Amyl nitrate by prescription.

What it feels like:
Dizzying rush. Alcohol-like intoxication. Distortion of senses and perceptions, delusions of grandeur. Dizziness, euphoria, weighlessness. Dissociation from environment. Silliness, awkward movement, muscle weakness. Altered speech, slowed reactions, altered judgment. Sensitivity to light, double vision, dilated pupils, ringing in ears. Drowsiness, sleep, anesthesia, depression, hallucinations, delirium, disorientation.

What it does:
To Your Mind: In most cases, depresses central nervous system. Nitrites stimulate.
To Your Body: Interrupts and increases heart rate, alters breathing.
Special Characteristics: Cheap and easily available, solvents are often used by adolescents who knowingly risk life-threatening effects to bolster self-esteem or gain peer approval. Nitrate blackout results from combination with other drugs.

How it can hurt you:
Toxic effects of inhalation of combined substances. Bizarre behavior. Severe depression, toxic psychosis. Pains in chest, muscles and joints, hangover, amnesia. Coma, seizures, brain damage, paranoia, nerve damage. Liver and kidney damage, respiratory tract damage, accumulation of body lead levels. Bone marrow deterioration, blood abnormalities, tremors, sleep disorders. Fatigue, loss of appetite, bronchial tube spasm, "glue sniffer's rash" (sores on nose and mouth). Nosebleeds. Nausea, diarrhea, eye/nose irritation, glaucoma, blood cell damage.

Death can come from "SSD" (sudden sniffing death), plastic bag suffocation, bizarre and reckless behavior, driving under the influence, poisoning of users and small children, suicide or respiratory depression. With fluorocarbons, death may be caused by "airway freezing" suffocation.

When to get help:
Do you think about how and when you're going to use drugs again?
Is your work or school performance affected?
Are you having problems with family and friends?
Is your drug use beyond what you can afford?
Do you use other drugs in addition to inhalants?

One "yes" and your common sense tells you it's time to get smart about drugs and the rest of your life.

Fact: Small amounts of inhalants can be instantly fatal.

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APPENDIX J

DSM-IV Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance abuse; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

3. recurrent substance-related legal problems (e.g., arrests fro substance-related disorderly conduct)

4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

DSM-IV Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the samea 12-month period:

1. tolerance, as defined by either of the following:
   a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b) markedly diminished effect with continued use of the same amount of the substance

2. withdrawal, as manifested by either of the following:
   a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

3. the substance is often taken in larger amounts or over a longer period than was intended

4. there is a persistent desire or unsuccessful efforts to cut down or control substance use

5. a great deal of time spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects

6. important social, occupational, or recreational activities are given up or reduced because of substance abuse.

7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

From the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Washington, DC, American Psychiatric Association, 1994.

GLOSSARY

abstinence - doing without; specifically, not using alcohol or other drugs

blackout - temporary loss of consciousness or conscious memory

blood alcohol concentration - level of alcohol contained in the bloodstream

central nervous system - brain and spinal cord

circumference - the distance around a circle

co-dependent - one who shares life with a chemically-dependent person and adapts behavior to adjust to abnormal conditions brought on by addiction

coma - unconsciousness beyond arousal

convulsion - severe, involuntary muscle spasm, usually with loss of consciousness

cross-tolerance - insensitivity to similar effects of other drugs

dependence - (or addiction) craving or physical need for a drug which interferes with physical and mental health, social responsibility, and well-being

depressant - drug which slows functions of specific organ system

designated driver - member of a group who volunteers to abstain from drinking in order to drive

dissociative - feelings of separation or distance from situation

drug - any natural or manufactured substance with physiological or psychological effects

euphoria - heightened feeling of happiness, well-being

Fetal Alcohol Effects - less severe (than Fetal Alcohol Syndrome) birth defects linked to alcohol use during pregnancy

Fetal Alcohol Syndrome - a pattern of mental and physical defects linked to heavy alcohol use during pregnancy

gonorrhea - a venereal disease causing a thick discharge from the sexual organs

hallucination - an unreal perception believed to be real

hepatitis - inflammation of the liver related to toxic substances or viral infection

impair - to damage, to cause weakening of

impulsive - having a sudden inclination to act, without thought for the consequences

inhibition - repression of or resistance to an instinct or impulse or feeling

intoxication - both inebriation and poisoning

narcotic - a drug which has a numbing or deadening effect

neurological - concerning the nerve system

overdose - amounts over the prescribed or indicated doses that produce damaging effects

paranoia - extreme suspicion

postnatal - occurring or existing immediately after birth or after giving birth

prenatal - occurring or existing before birth or before giving birth

psychoactive - affecting emotions, thoughts, behavior

schizophrenia - bizarre behavior with extreme disturbances in thought and mood

seizure - convulsions or other physical of psychic evidence of abnormal electric activity in the brain

side effect - effect, usually undesirable, which accompanies primary desired effect

solvent - liquid used to dissolve other substances

stimulant - drug that speeds up functions of specific organ system

syphilis - a venereal disease transmitted by contact or contracted by an unborn child from its mother's blood

tolerance - body adaptation to repeated drug effects requiring increased dosage for original experiences

toxic psychosis - severe mental disorder caused by psychoactive substances

withdrawal symptoms - physical and psychological effects when use of drug is stopped

ACRONYMS GLOSSARY

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
BAC	Blood Alcohol Concentration
CAC	Credentialled Alcoholism Counselor
CDC	Center for Disease Control
CNS	Central Nervous System
DAAA	Division of Alcohol Abuse
DARE	Drug Awareness Resistance Education
DSAS	Division of Substance Abuse Services
DWAI	Driving While Ability Impaired
DWI	Driving While Intoxicated
EAP	Employee Assistance Program
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
HIV	Human Immunodeficiency Virus
IV	Intravenous
MADD	Mothers Against Drunk Driving
NA	Narcotics Anonymous
NIAAA	National Institute on Alcoholism and Alcohol Abuse
NIDA	National Institute on Drug Abuse
NYS	New York State
OASAS	Office of Alcoholism and Substance Abuse Services
OTC	Over The Counter
PCP	Phencyclidine
RID	Remove the Intoxicated Driver
SADD	Students Against Drunk Driving
SSD	Sudden Sniffing Death
STD	Sexually Transmitted Disease

12-STEP AND RECOVERY PROGRAMS - COMMONLY USED TERMS

Easy does it.

Try not to let your mind race. Take things easy (but do it). Know how to relax.

First things first.

Being clean and sober is the first priority.

Give time time.

We need to practice patience, and realize that everything can't be accomplished in a day.

If you want what we have, there are certain steps you have to follow.

People in recovery find peace and serenity through following the 12 steps in the program.

Keeping it green.

Seeing an active alcoholic or drug addict reminds us of how we used to be. To "keep it green" many people go to detox meetings.

Just for today.

Stay away from a drink or a drug today. Wait for tomorrow to come and again it will be today.

Live and let live.

Live your own life and let others live as they want to.

Live life on life's terms.

We can't control how others think, talk, or act, so we need to let people be who they are, and give ourselves permission to be who we are.

No pain, no gain.

Sharing past experiences helps to ease the pain of those experiences, and allows people to move on to new experiences.

One day at a time.

Live only a day at a time. Don't project the future. It's okay to make plans and goals, but realize that we are not promised a tomorrow. We only have this moment to enjoy.

There but for the grace of God go I.

People in recovery can be thankful for what they have rather than condemning someone less fortunate.

Think, think, think.

People may do things compulsively without thinking about them or their consequences. Try to be aware of why you're doing something.

Throw your shoes under your bed.

This is told to many newcomers to a program. In order for them to get their shoes in the morning, they have to get down on their knees. While they are there, they can give thanks to their higher power.

You're only as sick as your secrets.

If you don't share your secrets, you will not be able to experience the peace of mind needed in order to live a life without using alcohol or other drugs.

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